CITY OF SALFORD

ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH 1966

City of Salford

ANNUAL REPORT

OF THE

Medical Officer of Health

FOR THE YEAR

1966

BY

J. L. BURN, M.D., D.Hy., D.P.H.,

MEDICAL OFFICER OF HEALTH

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at 31st December, 1966

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INTRODUCTION

" The health of the people is really the foundation upon which all their happiness and prosperity as a State depend..... The great question, the great social question, which should engage the attention of statesmen, is the health of the people."
(Disraeli)

MR. CHAIRMAN, LADIES AND GENTLEMEN,

Health is our business and we seek to make it worthwhile and attractive to the consumer. We have had successes and failures during the year – to take the worst first – our perinatal and infant mortality rates were far too high. Special attention, fortunately, was given by systematic study of the causes of high perinatal mortality in 1965 and after, by Dr. David Vaughan. This report is included in the text and repays full and careful study.

SALFORD – OUTBREAK OF SMALLPOX

This outbreak came to light on 16th July when a 52 year old woman who had never been vaccinated was admitted to the Infectious Diseases Hospital suspected to be suffering from chickenpox.

The outbreak involved two families and spread of infection was probably through the children who played together.

Thirteen cases occurred in all; a retrospective diagnosis was made and in five cases the diagnosis was confirmed; by virus isolation in seven cases. A full report of the lessons learnt from this outbreak will be appearing in the medical press.

A CASE OF TYPHOID FEVER

During the Whitsuntide Holidays, two 13 yrs. old boys went camping on a river bank in Cheshire, during which they drank some water from the river.

Approximately two weeks after this holiday, one of the boys developed symptoms of vomiting and fever and was eventually admitted to Isolation Hospital where Typhoid Fever was diagnosed. His companion on the holiday remained in good health.

All contacts of the two boys were traced and submitted daily urine and faecal specimens for the length of the incubation period, in addition blood specimens were taken from immediate contacts. Personal hygiene and modes of infection were explained to all concerned. Both mothers of the boys, who were engaged in food handling, were stopped from following their employment.

All specimens submitted proved negative and what could have been a serious outbreak was confined to one case.

Chemical analysis of the river concerned showed that approximately ¼ of the river flow was sewage effluence, the river was rat-infested and numerous bacteriological swabs placed in the river revealed cultures of various salmonella, but not the salmonella typhi implicated in this case.

ENVIRONMENTAL HYGIENE

The air is clearer nowadays, the colours are brighter and the drabness of bad housing is disappearing. Control of air pollution has helped the people's outlook on life to the brighter clothing, furnishings and the shades of the buildings.

SUGGESTIONS IN THE CONTROL OF AIR POLLUTION

There should be an element of compulsion in smoke control. In the event of any local authority failing to carry out smoke control, the Ministry of Housing and Local Government should carry out this duty in default.

More selective use of fuels should be used in some industries in times of fog and high pollution. Greater use could be made of gas, of low sulphur oils. There are no restrictions whatsoever at present.

Desulphurisation of oils at source might be encouraged.

Better roads are needed to prevent traffic hold-ups in cities. This is responsible for much unnecessary pollution. More roads of motorway standards would help. In the meantime there should be more Ministry of Transport checks on vehicles and all vehicles emitting gases above the prescribed level to be banned from the road until repaired.

Greater control over dust, smoke, fume or smell-producing industries and processes is now imperative. To deal with smell one has to prove either nuisance or that it is prejudicial to health – in many instances this is intrinsically difficult. Certain processes are controlled by the Alkali Inspector and not by the local authority and the Alkali Inspector has to cover a very large area and so lacks the advantage of being on the spot which is possessed by the local authority. Larger local authorities could deal with these emissions as and when they occur.

The progressive clearance of slum property (in 1966 nearly 5,000 people were rehoused), the improvement of dwellings by the provision of baths and hot water and the clear atmosphere, the result of smoke control, contribute in lifting the burden, especially for housewives fighting against dirt.

In this progress in all our activities a tribute must be paid to the dedication of the staff who have shown so much enthusiasm in carrying out their work. Mindful of the work which has been done, but very conscious of the vast amount still undone, we look forward to a year of further progress in giving better housing, cleaner air and safe food to all.

"IN THE INTERESTS OF HYGIENE...." Many people see this notice on doors and windows of food shops. Generally, it requests the public not to bring dogs into food shops. But in the interests of hygiene it is much to be desired that people should not smoke in food shops. Cases have come to light where cigarette ash and smoke have contaminated foodstuffs and in the interest of everyone this should be avoided. It is not fair to the shopkeeper whose goods can be affected, nor to other shoppers.

Cigarette ends have been known to be embedded in some foods. It is horrible to think that this can happen and the shopkeeper and supplier of the foods could be held liable. It is quite wrong that they should be blamed, so we ask for the co-operation of consumers, shoppers and shop-keepers, wholesalers and retailers to stop any smoking in the shops and places of work. It is of course, an offence for the shopkeeper and his staff to smoke in a food shop, but it is a little unfair that shoppers have been able to do what they like.

I feel that we might well follow the example of some big stores where smoking by anyone is not allowed.

CARRYING OUT THE TEN YEAR PLAN

We shall have to revise our ideas about the use of staff by being more resourceful, by dilution, by deployment and delegation.. Present staff aren't sufficient to meet needs, but there is going to be a great deal of chronic sick, mentally sick, and subnormal sick, to come into the community. There is ever earlier discharge from hospital following operation.

From the district nurse increased work will come by caring for patients in their own home instead of daily visits by persons who take patients for dressings to out-patient departments; cases of breast abscesses requiring daily dressings. These could and should be done at home.

With the impact of modern psychology there will be a reduction of young children admitted to hospital. It is a disgrace that in industrial urban areas some babies and young children are admitted unnecessarily to hospital may-be several times in a year on account of gastro-enteritis, dysentery, bronchitis.

All the time there is an increase in the number of aged people in the community. For example more people are in the cancer age and this means that old people's care must devolve on the community rather than the family will still operate.

There will be need for decentralisation of staff as it will be wasteful to send staff out from central health departments the way so many do at present.

Queen's nurses particularly are likely to be in short supply.

Then again, the number of group practices is increasing throughout the country. These deserve and need more time from health visitors and district nurses.

TRAINING

There will be an increased demand for in-service training. All the part-timers, the mature woman coming back to nursing will need instruction in the new techniques, drugs, and so on. This can surely best be done on a regional basis irrespective of local government boundaries.

Nowadays "whole-timers" need periodic revision courses. For the enrolled nurses three pilot schemes are in operation whereby modern district nursing techniques are passed on. Nursing auxiliaries of both sexes will be required for bathing; hair-washing; foot; and toilet; dressing and undressing patients who need assistance, and so on.

There is the help of our good friends the British Red Cross, and St. John Ambulance Brigade, whilst the Marie Curie Foundation is a wonderful help in cancer cases.

HOME HELP SERVICE

The status and standards of the service are being slowly and steadily improved.

Each of the three Assistant Organisers is responsible for a division of the city in conformity with our general policy. This means that they can link up with geriatric services where the three Special Health Visitors have similar responsibilities in their geriatric visiting. The greatest importance is attached now to co-operation with other Staff – Health Visitors and District Nurses – to promote the greatest efficiency. Higher standards are expected of new-comers to the Home Help Service; special attention has been given to making the services available during weekends and long holidays.

Very few mothers who have delivery at home wish to use the Home Help Service. Far too few ante-natal cases, suffering from minor degrees of toxaemia of pregnancy, are helped.

FAMILY DOCTOR HEALTH TEAMS

One of the greatest benefits to the work of members of these teams is the way in which they can work with the authority of the family doctors behind them. The management of cases can be discussed; knowledge of the patient's past and present environment – using that term in its psychological and social as well as physical aspects – will have been exchanged and a clear plan of care can emerge. This knowledge shared by the health visitor and her colleagues and members of a team enhances the confidence and comprehensiveness of the approach to the problems which some patients present. There can hardly be conflicting opinions as there are opportunities to discuss the patient's total care beforehand. Certainly, family doctors in my area have usually experienced not only satisfaction but pleasure and high appreciation of the contribution of the team.

HEALTH CHECK-UP – Screening tests

A striking fact is that about half of the amputations of lower limbs which are carried out in this country are because of diabetic gangrene. It must be admitted that some authorities state that discovering diabetes early may have little or no effect on the progress of the disease. On the other hand, there are many experts who hold that it is very worthwhile to identify diabetes early. Probably most of us would agree with the second group. Patients have a right to know of the possibility of important complications developing in some diseases. They have only one life to live and it is only fair to them to know of their liability to serious chronic disease in order that they can modify their way of life and take appropriate precautions advised by their doctors.

Two recent cases have impressed me greatly – one an ulcer on the ball of the big toe, the other carbuncles on the neck. Both received local treatment of ointments and dressings for a long time, until someone had the wisdom to ask for a urine test. Sometimes district nurses have given injections of vitamins and anti-haematinic preparations to patients for many complaints when, in fact, the patient had underlying Diabetes.

Many authorities now ask their district nurses to test all new patients, but in this case it is preferable to screen the patient for as many conditions as possible with the one test.

Members of the Salford Health Teams themselves are encouraged to use a multistrip which screens for glucose ketones, protein, blood bile and pH within 30 seconds.

Cervical cytology is another condition which can be carried out by the team with the minimum of effort and the maximum response. Incidentally, it is desirable to ask the patient to empty her bladder prior to obtaining the cervical cancer "scrape" and to test the sample of urine by a Multistrip Test. Some mistakes which could be serious to the patient and embarrassing to the family doctor and to the public health staff can be avoided. We must not wait until some complication of a disease demands treatment before we find out the sufferer.

This "early warning system" is in line with the precept of Sir James Mackenzie who advised us all to "Study the beginnings of disease." Pre-symptomatic diagnosis is increasingly valuable for the future health and well-being of the individual and of the community.

Routine testing of the high risk groups (smokers, blood relatives of diabetics) is part of the practice of modern preventive medicine. I have before me a picture of a young man paralysed from the waist downwards and condemned to a wheelchair existence all his life. Unfortunately, his attack of polio came before the use of polio vaccination. Pre-systematic diagnosis may be just as worthwhile as vaccination against communicable disease, for both procedures seek to prevent important and preventable diseases.

STATISTICS

A few facts may be given, showing some aspects of the service provided in 1966.

Ambulance Service	over 100,000 patients and over ¼ million miles travelled
Ante-natal Clinics	nearly 8,500 attendances
Child Welfare Clinics	over 31,000 attendances
Day Nurseries	3 day nurseries ; 140 places
Domestic Help	275 home helps, working over ¼ million hours per year, assisting over 2,000 cases
Health Visitors and Clinic Nurses	65,000 visits; 2,500 clinic sessions
Home Nurses	62,000 visits; 2,300 patients
"Salford House" Municipal Lodging House	285 cubicles provided
Mental Health	2 hostels; 38 places 2 adult training centres; 120 places 2 junior training centres; 70 places
Midwifery	over 1,100 domiciliary births; over 25,000 nursing visits
Public Health Inspectors	nearly 2,000 samples taken; nearly 40,000 inspections, more than 50% of these are because of sanitary defects or smoke control; over 7,000 complaints received
Chiropody	7,000 treatments

FUTURE CHALLENGES

In 1966 the sample census showed that there were 5,350 men aged 60 and over and no less than 15,240 women; the total male population was 68,880 and females, 73,370. A challenging figure is the number of men 65 and over (700) living alone equalling 13% of the over-sixty population and there is the greater and sadder fact in the case of women of 60 and over living alone – 4,740 the equivalent of 31% of the women over-sixties. These facts suggest – nay, demand the need for more health welfare work amongst the aged. Some of our efforts are described in various sections of this Report.

A PROPOSED COMMUNITY DEVELOPMENT PROJECT

It is suggested that an area comprising of say up to 25,000 people be chosen. This could either be in the Lower Broughton or Trinity area, or the Langworthy or South Salford area.

The aim is to up-grade the area in every way, socially and environmentally – using the word "environment" in its "total" meaning – by finding out what the "felt needs" of the people concerned were and trying to meet those needs by securing the "self-participation" so essential for individuals in the community.

It would be advisable to appoint one social work organiser or a community development officer. He should be of University status and should be able to command the use of certain University resources, for participation of the Department of Social and Preventive Medicine, and the Department of Social Administration would be essential. Part of the project would seek to ascertain who were the natural leaders in the community in order to avoid dependence on outside help.

After the survey a most important part of the work of the duties of the social work organisers would be the guidance of these natural leaders in organising the various activities which are needed by the people. These might well include a variety of social clubs; women's classes; educational features and talks; various sports and camping facilities to be initiated or developed with full recognition of the extent of existing facilities. The organising work is the onerous part of the project. I cannot see any existing Corporation Department or group of departments providing the staff time for for this work. It must be "ad hoc" and full-time. Hence the necessity of special staff.

A permanent feature of the work would be the up-grading of the physical services, e.g. improvement grants, cleansing services, a special concentration of public health activity such as health visitors services as well as the encouragement of all measures to beautify the area, and make it so attractive that the people in other areas would wish to emulate.

Special thanks are due to the Women's Royal Voluntary Services and to the League of Jewish Women for their magnificent and inspiring help.

I would like to pay the warmest tribute to all members of the professional, administrative, clerical and manual staff for the good work they have done during the year. Some of those whose names appear on the list of staff given here have played a special part in the compilation of this Report, which is the work of many hands. To all who have helped, whether named or unnamed, special thanks are due, their devoted help has been of great assistance to the citizens of Salford.

To the Chairman and members of the Health Committee who have supported the staff in their work, I would like to express my sincere gratitude.

To my colleagues, the family doctors and to my fellow chief officers who have rendered help; to the Press and to the public, I would like to offer my grateful thanks.

I have the honour to be, Mr. Chairman, Ladies and Gentlemen,

Your obedient Servant,

J. L. Burn

Medical Officer of Health.

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STATISTICAL SUMMARY – 1966

(Based upon figures supplied by Registrar-General)

Area – The City of Salford has a total area of 5,203 acres			
Population – (Registrar-General's Estimate at Mid-year 1966)			145,880
,, – (Census, 1961)			155,090
Density – The Mean Density of the City is equal to 28·04 persons per acre			
Live Births – Legitimate:	1,256 Males	1,160 Females	2,416
,, ,, – Illegitimate:	156 Males	177 Females	333
		Total	2,749
Live birth rate per 1,000 population			18·8
Still-births: 26 Males	32 Females		58
Still-birth rate per 1,000 live and still-births			20·7
Total live and still-births			2,807
Infant Deaths (deaths under 1 year) Legitimate 82, Illegitimate 6			88
Infant mortality rate per 1,000 live births – Total			32
,, ,, ,, ,, ,, ,, ,, – Legitimate			33·9
,, ,, ,, ,, ,, ,, ,, – Illegitimate			18
Neo-Natal mortality rate (deaths under 4 weeks per 1,000 total live births)			21·5
Early Neo-Natal mortality rate (deaths under 1 week per 1,000 total live births)			18·5
Illegitimate live births per cent of total live births			12·1
Perinatal mortality rate (still-births plus deaths under one week per 1,000 total births)			
Still-births 58 / Deaths under one week 59		Total, 117	41·7
Maternal deaths (including abortion)			Nil
Maternal mortality rate per 1,000 live and still-births			Nil
Deaths: 1,054 Males; 978 Females;			2,032
Annual rate of mortality per 1,000 of the population			13·9

TABLE 1

SHOWING THE BIRTHS IN THE CITY OF SALFORD, DEATHS OF LEGITIMATE AND ILLEGITIMATE INFANTS UNDER ONE YEAR OLD AND THE PROPORTION OF DEATHS UNDER ONE YEAR OF AGE PER 1,000 BIRTHS DURING THE YEARS 1948 TO 1966..

Years.	Births.			Percentage of Illegitimate Births to Total Births	Deaths under One Year.			Proportion of Deaths under One Year per 1,000 Births.		
	Total.	Legit.	Illegit.		Total.	Legit.	Illegit.	Total.	Legit.	Illegit.
1948	3761	3570	191	5·1	157	147	10	42	41	52
1949	3628	3387	241	6·6	193	181	12	53	53	50
1950	3354	3123	231	6·9	144	128	16	43	41	69
1951	3091	2881	210	6·8	107	103	4	35	36	19
1952	3100	2913	187	6·0	107	89	18	35	31	96
1953	2964	2794	170	5·7	95	83	12	32	30	71
1954	2867	2692	175	6·1	87	79	8	30	30	46
1955	2700	2544	156	5·8	81	75	6	30	29	32
1956	2826	2682	144	5·1	83	80	3	29	30	21
1957	3026	2851	175	5·8	88	84	4	29	29	23
1958	.2930	2738	192	6·5	84	78	6	29	28	31
1959	2959	2789	170	5·7	71	67	4	24	24	24
1960	2991	2752	239	8·0	80	73	7	27	27	29
1961	3018	2769	249	8·3	85	79	6	28	29	24
1962	3199	2911	288	9·0	93	85	8	29	29	28
1963	3154	2832	322	10·21	98	95	3	31	34	9
1964	3053	2703	350	11·46	93	78	15	30	29	43
1965	3054	2701	353	11·56	80	71	9	26	26	25
1966	2807	2467	340	12·11	88	82	6	31	33	18

TABLE 2

SHOWING THE BIRTH RATES, RATES OF MORTALITY FROM ALL CAUSES, TUBERCULOSIS OF RESPIRATORY SYSTEM, CANCER, HEART DISEASES, BRONCHITIS AND PNEUMONIA AND THE INFANT MORTALITY RATES DURING THE YEARS 1948 TO 1966.

Years	Population estimated to middle of each year	Rates per 1,000 Population							Deaths under one year of age per 1,000 Births.
		Births	Deaths from						
			All Causes	Tuberculosis of Respiratory System	Cancer	Heart Diseases	Bronchitis	Pneumonia	
1948	178,100	21·12	11·81	0·78	2·16	2·44	1·14	0·48	41·74
1949	178,900	20·28	13·06	0·63	2·00	3·13	1·45	0·71	53·20
1950	177,700	18·87	12·87	0·50	2·31	3·51	1·30	0·46	42·93
1951	176,800	17·48	14·12	0·46	2·15	4·04	1·78	0·50	34·62
1952	176,400	15·57	12·19	0·35	2·12	3·35	1·33	0·59	34·52
Average 5 years		**18·66**	**12·81**	**0·54**	**2·15**	**3·29**	**1·40**	**0·55**	**41·40**
1953	173,900	17·05	12·36	0·29	2·24	3·24	1·59	0·74	32·05
1954	171,500	16·72	11·98	0·23	2·39	3·44	1·19	0·56	30·35
1955	169,300	15·95	12·30	0·22	2·08	3·46	1·33	0·78	30·00
1956	167,400	16·88	12·34	0·20	2·43	3·48	1·46	0·78	29·37
1957	165,300	18·31	12·97	0·19	2·44	3·75	1·37	0·79	28·75
Average 5 years		**16·98**	**12·39**	**0·23**	**2·32**	**3·47**	**1·39**	**0·73**	**30·10**
1958	163,600	17·91	13·20	0·12	2·20	3·70	1·56	0·84	28·67
1959	162,000	18·27	13·01	0·19	2·43	3·78	1·31	0·78	23·99
1960	161,170	18·56	12·67	0·13	2·44	3·60	1·21	0·62	26·75
1961	154,910	19·45	13·96	0·14	2·39	3·74	1·56	0·84	28·16
1962	154,000	20·77	14·90	0·08	2·42	4·23	1.67	0·91	29·07
Average 5 years		**18·99**	**13·55**	**0·13**	**2·37**	**3·81**	**1·46**	**0·79**	**27·33**
1963	152,570	20·67	13·29	0·06	2·41	3·38	1·42	1·15	31·07
1964	150,350	20·31	12·26	0·07	2·38	3·51	1·17	0·71	30·46
1965	148,260	20·60	12·97	0·05	2·58	3·84	1·19	0·78	26·20
1966	145,880	18·84	13·93	0·07	2·76	3·75	1·38	0·87	31·35

TABLE 3

STATEMENT SHOWING NUMBER OF DEATHS IN THE CITY OF SALFORD FROM THE DISEASES SPECIFIED REGISTERED DURING THE YEARS 1933-1966 AND THE RATES PER 100,000 OF THE POPULATION.

(a) Number of Deaths. (b) Rate per 100,000 of the population.

Year	Bronchitis		Cancer (all sites)		Heart Diseases		Pneumonia		Tuberculosis of Resp. system		Total Deaths	
	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)	(a)	(b)
1933	200	92·2	339	156·2	591	272·4	269	124·0	248	116·0	3009	1386·6
1934	133	62·2	400	187·1	637	297·9	243	113·6	201	94·0	2932	1371·1
1935	131	62·4	348	165·7	656	312·4	236	112·4	190	90·5	2734	1301·9
1936	154	74·8	352	170·9	729	353·9	249	120·9	207	100·5	2893	1404·4
1937	141	69·9	390	193·3	779	386·0	245	121·4	178	88·2	2943	1458·4
1938	86	43·1	344	172·5	691	346·5	210	105·3	192	96·3	2611	1309·4
1939	92	46·8	366	186·2	838	426·2	201	102·2	187	95·1	2698	1372·3
1940	535	308·9	342	197·5	754	435·3	221	127·6	195	112·6	3224	1861·4
1941	333	208·5	276	172·8	559	350·0	211	132·1	173	108·3	2743	1717·4
1942	239	155·9	387	219·8	462	301·4	129	84·1	146	95·2	2223	1450·1
1943	330	215·7	345	225·5	445	290·8	147	96·1	148	96·7	2382	1556·9
1944	271	173·9	328	200·5	461	295·9	101	64·8	151	96·9	2271	1457·6
1945	416	264·5	313	199·0	472	300·1	126	80·1	146	92·8	2459	1563·3
1946	289	170·5	326	192·4	444	262·0	127	74·9	122	72·0	2266	1337·1
1947	288	165·5	351	201·6	488	280·3	122	70·1	131	75·3	2312	1328·2
1948	203	114·0	385	216·2	434	243·7	86	48·3	139	78·0	2103	1180·8
1949	260	145·3	358	200·1	560	313·0	127	71·0	113	63·2	2337	1306·3
1950	231	130·0	410	230·7	624	351·2	82	46·2	89	50·1	2288	1287·6
1951	314	177·6	392	221·7	715	404·4	89	50·3	82	46·4	2497	1412·3
1952	235	133·2	374	212·0	591	335·0	104	59·0	61	34·6	2151	1219·4
1953	277	159·3	390	224·3	563	323·7	129	74·2	50	28·8	2149	1235·8
1954	204	119·0	410	239·1	590	344·0	96	56·0	39	22·7	2055	1198·3
1955	226	133·5	352	207·9	585	345·5	132	78·0	38	22·4	2082	1229·8
1956	244	145·8	407	243·1	583	348·3	131	78·3	33	19·7	2065	1233·6
1957	226	136·7	404	244·4	620	375·1	131	79·3	31	18·8	2150	1300·7
1958	255	155·9	359	219·4	611	370·4	137	83·7	20	12·2	2159	1319·7
1959	212	130·9	394	243·2	612	377·8	127	78·4	31	19·1	2107	1300·6
1960	195	121·0	393	243·8	580	359·9	100	62·0	21	13·0	2042	1267·0
1961	242	156·2	370	238·8	579	373·8	130	83·9	21	13·5	2163	1396·0
1962	258	167·5	374	242·9	651	422·5	141	91·6	13	8·4	2294	1489.6
1963	216	141·6	367	240·5	516	338·2	176	115·3	10	6·5	2028	1329·2
1964	176	117·1	358	238·1	528	351·2	106	70·5	11	7·3	1844	1226·5
1965	176	118·7	383	258·3	569	383·8	116	78·2	7	4·7	1923	1297·0
1966	202	138·4	404	276·9	548	375·7	127	87·1	10	6·9	2032	1392·9

CAUSES OF DEATH – Registrar General's Return of Deaths in the City of Salford during the year 1966

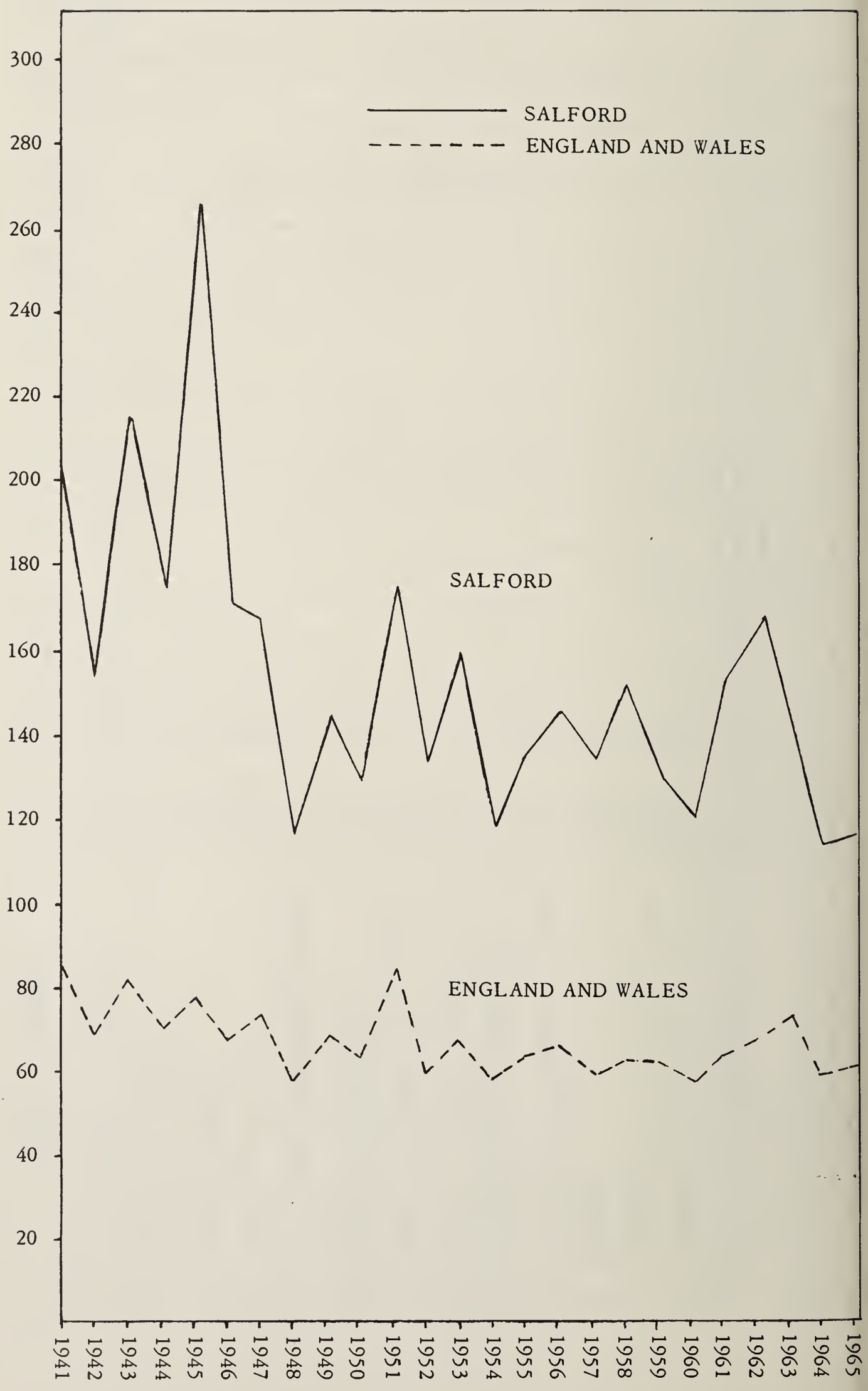
CAUSE OF DEATH	Sex	Total All ages	Under 4 weeks	4 weeks & under 1 year	AGE IN YEARS 1–	5–	15–	25–	35–	45–	55–	65–	75 and over
1. Tuberculosis, Respiratory	M	9	–	–	–	–	–	–	1	2	2	3	1
	F	1	–	–	–	–	–	–	–	1	–	–	–
3. Syphilitic Disease	M	1	–	–	–	–	–	–	–	–	1	–	–
	F	4	–	–	–	–	–	–	–	–	3	1	–
8. Measles	M	–	–	–	–	–	–	–	–	–	–	–	–
	F	1	–	1	–	–	–	–	–	–	–	–	–
9. Other Infective & Parasitic Diseases	M	–	–	–	–	–	–	–	–	–	–	–	–
	F	1	–	–	–	–	–	–	–	–	–	–	1
10. Malignant Neoplasm, Stomach	M	30	–	–	–	–	–	–	1	7	8	11	3
	F	33	–	–	–	–	–	–	–	3	2	9	19
11. Malignant Neoplasm, Lung, Bronchus	M	110	–	–	–	–	–	–	5	10	45	39	11
	F	18	–	–	–	–	–	1	2	2	5	3	5
12. Malignant Neoplasm, Breast	M	–	–	–	–	–	–	–	–	–	–	–	–
	F	22	–	–	–	–	–	–	2	6	5	3	6
13. Malignant Neoplasm, Uterus	F	13	–	–	–	–	–	–	2	4	3	4	–
14. Other Malignant & Lymphatic Neoplasms	M	78	–	–	1	–	–	4	1	11	17	28	16
	F	100	–	–	1	–	–	1	1	11	29	26	31
15. Leukaemia, Aleukaemia	M	4	–	–	–	–	–	–	1	1	–	2	–
	F	1	–	–	–	–	1	–	–	–	–	–	–
16. Diabetes	M	5	–	–	–	–	–	–	–	–	1	1	3
	F	20	–	–	–	–	–	–	–	1	8	5	6
17. Vascular Lesions of Nervous System	M	104	–	–	–	–	–	1	3	8	24	36	32
	F	146	–	–	–	–	–	–	–	2	13	45	86
18. Coronary Disease, Angina	M	221	–	–	–	–	–	1	4	21	72	82	41
	F	154	–	–	–	–	–	–	1	3	31	53	66
19. Hypertension with Heart Disease	M	8	–	–	–	–	–	–	–	–	1	4	3
	F	20	–	–	–	–	–	–	–	–	1	6	13
20. Other Heart Disease	M	52	–	–	–	–	–	–	2	3	10	15	22
	F	93	–	–	–	–	–	–	3	–	9	17	64
21. Other Circulatory Disease	M	19	–	–	–	–	–	–	–	3	7	6	3
	F	30	–	–	–	–	–	1	–	1	3	7	18

CAUSES OF DEATH — Registrar General's Return of Deaths in the City of Salford during the year 1966

CAUSE OF DEATH	Sex	Total All ages	Under 4 weeks	4 weeks & under 1 year	AGE IN YEARS 1–	5–	15–	25–	35–	45–	55–	65–	75 and over
22. Influenza	M	15	–	–	–	–	–	–	–	1	3	3	8
	F	15	–	–	–	1	–	–	–	–	2	1	11
23. Pneumonia	M	72	2	14	2	–	1	–	1	7	4	15	26
	F	55	–	5	1	1	–	–	–	3	4	12	29
24. Bronchitis	M	141	–	–	–	–	–	–	2	19	34	40	46
	F	61	–	1	–	–	–	–	–	1	9	15	35
25. Other Diseases of Respiratory System	M	16	–	2	–	–	–	–	1	2	2	6	3
	F	8	–	–	–	–	–	–	–	–	1	3	4
26. Ulcer of Stomach and Duodenum	M	10	–	–	–	–	–	–	1	1	3	2	3
	F	6	–	–	–	–	–	–	–	2	1	1	2
27. Gastritis, Enteritis and Diarrhoea	M	4	–	2	–	–	–	–	–	–	1	–	1
	F	7	–	–	1	–	1	–	–	–	–	2	3
28. Nephritis and Nephrosis	M	3	–	–	–	–	–	–	–	1	–	1	1
	F	1	–	–	–	–	–	–	–	–	1	–	–
29. Hyperplasia of Prostate	M	2	–	–	–	–	–	–	–	–	–	–	2
31. Congenital Malformations	M	10	9	1	–	–	–	–	–	–	–	–	–
	F	9	4	–	2	1	–	–	–	1	–	–	1
32. Other Defined & Ill-Defined Diseases	M	93	21	3	–	2	1	3	4	5	13	13	28
	F	117	23	–	1	–	–	–	4	3	8	16	62
33. Motor Vehicle Accidents	M	10	–	–	–	–	–	1	–	2	1	3	3
	F	10	–	–	2	–	–	1	–	1	1	3	2
34. All Other Accidents	M	23	–	–	–	–	3	1	2	1	4	3	9
	F	19	–	–	2	–	–	1	2	–	2	3	9
35. Suicide	M	13	–	–	–	–	–	1	3	4	4	–	1
	F	12	–	–	–	–	1	–	2	6	1	2	–
36. Homicide and Operations of War	M	1	–	–	–	–	–	–	1	–	–	–	–
	F	1	–	–	–	–	–	–	–	–	–	1	–
TOTAL ALL CAUSES	M	1,054	32	22	3	2	5	12	33	109	257	313	266
	F	978	27	7	10	3	3	5	19	51	142	238	473

BRONCHITIS

Death Rates per 100,000 of Population in Salford and England and Wales for the years 1941 – 1965



BRONCHITIS

Death Rates per 100,000 of Population in Salford and England and Wales for the years 1941 – 1965

Date	Salford	England and Wales
1941	208·5	87·8
2	155·9	70·1
3	215·7	83·0
4	173·9	71·9
5	264·5	77·7
6	170·5	69·5
7	165·5	75·3
8	114·0	58·3
9	145·3	70·6
1950	130·0	65·4
1	177·6	85·6
2	133·2	62·7
3	159·3	69·6
4	119·0	58·2
5	133·5	65·2
6	145·8	67·0
7	136·7	60·3
8	155·9	65·2
9	130·9	64·0
1960	121·0	57·9
1	156·2	67·9
2	167·5	71·3
3	141·6	75·1
4	117·1	60·6
5	118·7	62

ENVIRONMENTAL HYGIENE

HOUSING: SLUM CLEARANCE AND IMPROVEMENT

The demolition of 1,400 unfit properties and the re-housing of the families in new accomodation during 1966 is a praiseworthy achievement and great credit is due to all concerned. If progress at this rate could be maintained then the future clearance of the bulk of Salford's unfit houses could be anticipated with confidence in a little over a decade. Unfortunately, at this time, no clear picture can yet be seen of the end of our problem of unfit houses.

At the average rate of progress of 804 unfit houses closed or demolished each year during the five year period 1961 to 1965 inclusive, it would take about 20 years to clear the backlog of houses classified as unfit at this present time. Detailed studies by officers of the Housing Working Party (a working committee of senior officers concerned with all aspects of housing work under the chairmanship of the Council's senior solicitor) show that it will be difficult, if not impossible, even to maintain this rate of progress, based on our present estimates of land availability. The projected annual output of new dwellings, upon which our clearance programme is so utterly dependent, shows a frightening fall in the early 1970s. It is true that the search for new overspill sites may successfully produce new areas acceptable to Salford families but this will surely only tend to defer the problem for a few years.

Salford's main impediment to the speedy clearance of her unfit houses is simply her chronic shortage of land capable of being developed for housing purposes. The will to build houses is there but the land is not. Unless this chronic strangulation can be overcome, then the shame of Salford's unfit houses will remain for generations to come.

It is impossible to forecast the future but one feels bound to point out simply and clearly that bad housing, with the manifold effects on family unity and on the physical and mental well being of our families, is still Salford's most serious and most urgent problem. If this problem remains unsolved then we will all have failed in our duty.

From a purely material achievement point of view, 1966 was a year of fine progress for our City; the following tables show what this achievement meant in the re-housing of families from old and worn out houses.

Unfit houses demolished or closed during 1966 (involving family rehousing) and including individually Unfit houses

Period	Dwellings	Persons
1st Quarter 1966	249	879
2nd Quarter 1966	309	1,034
3rd Quarter 1966	414	1,369
4th Quarter 1966	405	1,430
Totals	1,377	4,712

It is surely no mean achievement that almost 5,000 persons were given a better home environment in a single year.

In addition, some 25 other families found their own accomodation.

The following tables give factual details of the numbers of properties subject to specified action in an overall clearance programme. It is with humility that we claim that at every stage in the many processes we are acutely aware that in the clearance of unfit houses we are dealing, not only with bricks and mortar, but with people – with families each with their own particular problems, desires and hopes. That not all these hopes can be gratified is unfortunate but the end product is a much higher standard of housing for all concerned.

Clearance Areas Represented During 1966

Area	No. of dwellings	Type of Order
Cheetham (Extension) Clearance Areas	160	C.P.O. Dem. Immed.
Ordsall Hall Clearance Areas Nos. 1A and 1B	827	C.P.O. Dem. Immed.
Lower Broughton Clearance Areas Nos. 2A/E	590	C.P.O. Def. Dem.
Lower Broughton Clearance Areas Nos. 2F/G	407	C.P.O. Def. Dem.
Additional house and house/shop properties associated with clearance areas and included within the relevant Compulsory Purchase Order.	28	
Total all Properties	2,012	

Orders Confirmed During 1966

Area	Order	Property	Action
Lower Broughton Road (Nos. 250/252) (Houses in multiple occupation)	C.O.	2	Rehousing, demolished by order
Great Clowes Street Nos. 1 and 2 Clearance Areas (Houses in multiple occupation)	C.P.O.	12	Entry, rehousing commenced, clearance in operation
Clarendon Road No. 1, Clearance Area	C.P.O.	469	Do.
Clarendon Road No. 2, Clearance Area	C.P.O.	259	Do.
Devonshire Street Clearance Area (houses in multiple occupation)	C.P.O.	7	Do.
Clarendon Road Nos. 3A, B and C Clearance Areas	C.P.O.	157	Do.
Ellor Street No. 9, Clearance Area	C.P.O.	194	Entry, to be effective, January 1967

Individually Unfit Houses

Individually unfit houses subjected to either demolition or closing order procedures totalled 63 during the year from which the families were rehoused.

It is a difficult task to sift out and select those houses for which closure or demolition is the only possible course of action – there are so many properties so unfit as to merit this course of action that a strict balance must be kept to avoid diverting too high a proportion of our new houses to the rehousing of families from individually unfit houses. By agreement with the Housing Committee we attempt to limit the number to about 50 such houses each year but restricting the number becomes even more difficult.

Public Local Inquiries

Public local inquiries into fifteen clearance areas contained in five separate Compulsory Purchase Orders involving over 1,200 properties were held during the year. Two additional orders – one compulsory purchase order, one clearance order, involving 9 houses in multiple occupation were confirmed without objection. Two senior public health inspectors were responsible for the preparation of the representations and reports to the Committee, gave detailed evidence on the condition of the properties subject to objection and accompanied the Ministry Inspectors to the premises concerned.

Rehousing (Removal and Disinfestation)

The Council undertakes the removal of the household furnishings and personal effects of families displaced from Clearance Areas and from individually unfit houses. Removals are carried out on a competitive tender basis and the Council's current contractor undertakes removals on a minimum of 24 hours notice.

In all cases, except where families have found their own accommodation, it is the Council's policy to insist upon the disinfestation of furniture and effects prior to rehousing. In all cases this is carried out by trained operators of the department's disinfestation service free of charge to the families concerned. All vacated properties are disinfested prior to demolition.

Deferred Demolition (Section 48 Housing Act 1957)

The continuation of the use of the power to defer the demolition of selected groups of clearance area properties still remains a vital part of Salford's overall clearance programme.

Ideally, of course, all clearance area properties should be demolished as soon as possible after confirmation of each particular order but with a total of over 15,000 unfit houses still remaining to be cleared at the end of 1966 it is obvious that many years of hard work will remain before the end of clearance of unfit houses comes into sight. It must also be clearly obvious that the clearance of houses from land capable of being redeveloped for housing purposes, must take precedence over the clearance of houses from land, the speedy re-development of which is not possible for a variety of reasons.

By choosing carefully the type of area to which their powers of deferment are to be applied and by utilizing their powers of discretion to close or demolish groups of houses in these areas and to patch up and make more tolerable the fabric of the remaining houses it is believed that Salford has evolved a system best suited to her own particular problems.

The families from the very bad houses, incapable of even being made more tolerable for the time being benefit from their early re-housing; the families in the houses which remain after patch maintenance at least know that this ultimate re-housing is ensured and at least they have ready access to necessary repairs and maintenance work.

The deferment of demolition of specific areas, practised in Salford since 1955, has found approval and confirmation in paragraph 68 of the report "Our Older Houses – A Call for Action" which states :

68)....."We would expect that authorities which cannot deal with all these present unfit houses within seven years to justify this programme to the Minister and for these houses which must stand between seven and fifteen years, to undertake programmes of acquisition and "patching" under the powers at present laid down in sections 46 and 48 of the Housing Act 1957".....

A minimum of seven years of deferment of demolition is the general rule except for the properties which are closed or demolished immediately. The management and control of deferred demolition properties is in the hands of the Housing Committee who assume this responsibility after entry has been effected. A close and active liaison exists between the officers of both the Health and Housing Committees and recommendations for closure, for demolition or for patch maintenance made by officers of the Health Committee are speedily executed.

Immediate Demolition Areas

Clearance Areas are classified for immediate demolition when it is planned that the clearance of the properties and the rehousing of the families will take place within twelve months of entry upon the property. Almost without exception there are areas of seriously unfit houses chosen for speedy clearance and the redevelopment of the site for housing purposes.

Of great concern to all officers is the rapid deterioration in living conditions once re-housing commences. Vandalism, senseless and unnecessary damage by adults as well as by children, together with the dirt and discomfort of life amongst the process of demolition, create special problems almost incapable of solution.

The necessity to maintain essential services, to carry out emergency repairs to roofs and to deal with dangerous conditions are met by a simple, but effective, emergency work scheme, enabling the public health inspector in charge of clearance area procedures to order the necessary work without delay.

Much distress and uncertainty can be avoided when families in clearance areas are kept fully informed of the progress and intentions for re-housing and when simple yet detailed information is given on such matters as removal arrangements, the reporting of urgent works or dangerous conditions, responsibility for the maintenance of services and arrangements for the disposal of unwanted pets. The following routine information sheet in the form of a letter is given to all families in clearance areas as soon as possible after confirmation of the order and entry upon the properties :

Dear Sir or Madam,

TO THE OCCUPIERS OF DWELLING HOUSES AND HOUSE/SHOP PREMISES IN THE ELLOR STREET No. 9 CLEARANCE AREA

You have recently received the Council's Notice of Entry on your premises and the re-housing of families and demolition of properties will take place during the coming year.

The following information is given for your benefit and to keep you informed of the normal procedures adopted in dealing with clearance area properties.

Your co-operation is invited in order to reduce to the minimum the inconvenience which may be caused to you or your neighbours.

1. Essential services, wastage of water, dangerous conditions, urgent repairs

No routine repairs will be carried out on the property you now occupy. If, however, there are any dangerous conditions, instances of serious wastage of water or cases of extensive raining in, then you should complain to the Public Health Inspectors' Department, (Housing Section) Crescent, Salford, 5 (telephone 736 5891. Ext. 262), when the matter will be investigated and such emergency repairs as may be necessary will be carried out.

2. Disinfestation

It is the policy of the Council to insist that all furniture and effects of families from a Clearance Area to a Corporation property shall be disinfested.

This treatment (spraying) is carried out by the Health Department's Disinfestation team – free of charge.

3. Removal Arrangements

The Council undertakes the removal of household furniture and the effects from your present house to your new address.

This service is free of charge to tenants, providing the Council's contractor is used.

Arrangements for your removal will be made by Officers of the Health Department once you have accepted the Housing Manager's offer of new accommodation.

When you have confirmed your tenancy, of the new property, you are requested to write, telephone or call at :–

The Health Department,
(Public Health Inspectors' Section),
Crescent, Salford, 5. 736 5891 Ext. 262

giving at least 3 days notice of when you wish to remove.

Every effort will be made to move you on the day you request, but because of the large number of removals which have to be carried out this may not always be possible.

No removals are carried out on Saturdays or Sundays.

If there are any special difficulties in connection with chronically sick persons or aged persons, special arrangements will be made.

If you wish you may employ your own removal contractor but you must meet the cost yourself. You must, however, notify the Health Department in good time in order that disinfestation and cutting off of essential services may be carried out.

4. Firegrates, sinks and other fixtures

There have been instances in the past of tenants removing or dismantling firegrates, sinks and other fixtures and disposing of them. I must point out to all tenants that such unauthorised interference is a serious matter. Any instances of this occurring will be reported to the Council with the object of instituting legal proceedings against the offending tenants.

5. Gas, water and electricity services

The Health Department will notify the Gas, Electricity and Water Departments when your removal has been arranged in order that supplies may be cut off.

6. Pets

If you have any pets, cat or dog, that you are not permitted in the new accommodation, please do not abandon them but request the R.S.P.C.A. to dispose of them.

Cats – 305 Eccles New Road, Salford 5. Tel. 736 1231

Dogs – 41 Grange Avenue, Levenshulme,
Manchester. Tel. 224 8939

7. Re-housing

Any questions concerning the accommodation offered to you should be taken up with the Housing Manager and his staff, either by letter, personal call or telephone inquiry to:–

The Housing Department,
Eccles Old Road,
Salford 6. Tel. 736 2224

Safeguards – Mortgage Advance Scheme

During 1966, over 300 individual assessments of property were given to the City Treasurer upon request to assist in the consideration of applications made to the Council for mortgage advances. The reports are kept simple and relate to the following matters:

(a) Classification (fit or unfit – sec. 4 Housing Act 1957)
(b) General condition
(c) Estimated life

It is hoped that the adoption of this procedure will prevent the granting of mortgages on properties likely to be included in a future clearance programme as unfit.

Properties inquiries: a) Industrials, b) Commercial firms

The Council has always believed that it has a duty to make information available concerning their future clearance proposals particularly in the in the case of persons wishing to buy or sell property within the City.

In all cases of inquiry an attempt is made to give basic information (in writing) within 72 hours of receiving the request. A small charge of 5/- per property is made where the inquiry comes from an estate agent, solicitor or commercial firm but no charge is made for inquiries from private persons. This service is in addition to the normal "search questionnaire" and has been introduced because of the large numbers of private sales or purchase agreements made in respect of older type houses in Salford; many of these arrangements in the past have been made without the benefit of a solicitor's services, official searches or even written inquiries. Several hundreds of such property inquiries were answered during the year.

Every effort is made to ensure that the information is given by a senior Public Health Inspector, in writing. The casual answering across the counter or on the telephone is avoided whenever possible.

HOUSES IN MULTIPLE OCCUPATION

With the commencement of the Housing Act1961, it was estimated that there were 250 multi-occupied houses in the City.

At the end of 1965 it was thought that the real figure was nearer 480, further work in this field has revealed that the true figure is around 700.

In 1965 the Department was unfortunate in losing the services of a Public Health Inspector who had specialised in this kind of work.

The shortage of qualified staff made it impossible to continue systematic inspection of houses in multiple occupation until November, 1966, when the Department obtained the services of a mature inspector.

The number of houses in multiple occupation included in the register at the end of 1966 was 407. However, it is in my opinion, doubtful whether the true figure will ever be known, as there are so many large houses within the City which can be easily converted for this type of housing, and as residents move out due to deteriorating envionmental conditions so these houses are purchased and put to this use.

The condition to be found in houses of this type varies from ideal to squalid and I regret to say that squalid conditions are more prevalent that the ideal. I feel that this is a problem which requires constant attention and supervision and it is hoped that in the ensuing year that the Department will be able to give this matter the attention and supervision it requires.

Opportunities were taken during 1966 to close or demolish either individually or by small compulsory purchase or clearance order proceedings some 24 houses in multiple occupation where conditions had deteriorated to such a degree that no other course of action was possible.

There is no doubt, that but for the adverse effect on the overall clearance programme and housing lists etc., the relevant powers to close or demolish houses in multiple occupation either individually or in small groups would be used to a much wider extent.

IMPROVEMENTS

Improvement Grants

The number of applications for grants received during the year again showed a slight increase over the previous twelve months due mainly to publicity and pressure upon owners by the department.

Grant payments totalling £13,925 0s 5d were made in respect of 159 dwellings.

Tenants' Representations for Improvement

Representations were received from 20 tenants of rented dwellings not situated within Compulsory Improvement Areas, for the Council to compell the owners to carry out works necessary to provide the houses with the 5 standard amenities.

The owners have been notified of these representations and in 16 cases Improvement Notices have been served, requesting that these works be carried out within the statutory time limits.

Formal action by the department upon tenants' behalf has resulted in 16 applications for improvements grants being received from owners during the year

Compulsory Improvement Areas

Continued efforts were made in the fields of compulsory improvement of whole areas by the provision in all tenanted houses; of a bath, wash hand basin, hot and cold water supplies, internal water closet and facilities for the storage of food.

A further area was decleard to be an Improvement Area and approaches to owners, tenants and owner/occupiers indicated that substantial success could be expected within the next twelve months.

TABLE 1

Compulsory Improvement Area declared during 1966

Area	No. of Properties	No. Already Improved	Tenanted	O/Occ	No. of grant applications received
Duchy Road	115	10	69	46	6

Results in the existing Improvement Areas are not as good as had been envisaged but this was due to shortage of staff for a considerable period of the year and the extremely lengthy enforcement procedures necessary under the provisions of the Housing Act 1964.

TABLE 2

Progress within Improvement Areas

	No. of Properties	Already Improved	Grant applications received	Total houses improved	Houses subject to Statutory Notice	Notes
Seedley No. 1	254	20	114	105	–	Persuasive Improvement Area
Seedley No. 2	206	48	67	105	–	as above
Lr. Broughton (Grecian St.)	239	5	88	60	99	Compulsory Improvement Area
Langworthy No. 1	329	–	50	12	196	as above

Attempts were again made to bring the provisions relating to improvement to the notice of the general public by means of circularising occupiers of areas suitable for improvement and by the display of posters in all local offices.

The Ministry of Housing and Local Government's mobile exhibition also visited Salford and was stationed at the Health Department for four days and at the Market on the two market days. The number of genuine enquiries made on these occasions was quite encouraging.

Future Programme

The Ministry of Housing and Local Government has urged local authorities to accelerate their Compulsory Improvement programmes and to encourage owners to take advantage of Improvement Grant schemes.

Salford is one of the few authorities to make a serious attempt to tackle this problem; many discussions have been held both with the Ministry Officials and local Members of Parliament on methods of simplifying the existing cumbersome legislation to allow for a more speedy action by the Council.

It is expected with the staff now employed upon these duties and with the probability of changes in legislation, our target of 500 houses improved a year may become a reality in the future.

DRAINS AND SEWERS

During the year, 2,507 complaints were dealt with by the Drainage Inspector and his two assistants in respect of defective drains and sewers, which includes complaints from the Housing Department in respect of Corporation owned property. Simple blockages were removed by rodding and plunging and no charge made for this service.

Work was carried out on 48 sewers under Section 24 Public Health Act by the City Engineer and the work was inspected whilst in progress and on completion by the Drainage Inspector. Notices under Section 24 Public Health Act are served by the Chief Public Health Inspector. The Highways Surveyors' Department and the Drainage Inspector are in daily contact, dealing immediately with urgent sewer complaints as they arise.

In respect of notices served under Section 39 of the Public Health Act, work was carried out at 36 premises in default. The cost of carrying out this work was £1,013 7s. 1d, which is recoverable from the owners of the premises concerned. This is an increase of 12 properties over the preceding year and may be partly attributed to an increase in the number of houses becoming owner/occupied. Due to their financial status they are unable to obtain a contractor when drainage trouble occurs and contractors are aware that drainage work can be costly and avoid taking on work where they are of the opinion that they may not be paid.

Contractors on the whole co-operate with the Drainage Inspector in carrying out work to drains and usually advice and assistance is sought whilst work is in progress. A case occurred during the year where a contractor opened up on a drain in a rear yard which was eight feet deep, using no timbering for support. Consequently the ground eroded and upon first inspection by the Drainage Inspector at the request of the owner/occupier it was found

that the ground had gone from beneath a party yard wall and was in danger of collapse. Also on the rear addition house wall the arches over the scullery windows had slipped and the brickwork of the house wall had fractures. It was found that the contractor was a one-man firm and was carrying out this work on occasional days and half days. Requests were made to him to carry out shoring but the attempt was unsatisfactory and consequently a notice was served upon the owner and the work carried out in default by the City Engineer. The work involved taking down the yard wall and timbering to the excavation before the drainage work could be carried out and the final cost was approximately three times what it would have been had the work commenced and been carried out in a proper manner. It cannot be emphasised enough that a reputed contractor be engaged to carry out drainage work.

The Drainage Inspector and Pests Inspector work in close co-operation in investigation of rat complaints and usually after smoke testing a defective drain or sewer is found which is allowing the rats to escape.

Compared with previous years only isolated complaints of sewer gas have been received which may be partly attributed to the mild winter and and also by the regular visits of the Trade Effluent Inspector to the Gas Works to take temperature and samples of trade effluent at the drain outlet into the Public sewer.

Complaints of percolations into cellars and sub-floors were dealt with by colour testing of drains and sewers and in most cases were found to be due to a defective drain. Where a negative re-action was obtained. the Manchester Water Works Department was informed and tests were carried out by them on water service pipes and mains for bursts.

Inspections were carried out by the Drainage Inspector of drain and sewer repairs, or reconstruction, by private contractors in accordance with Section 41 of Public Health Act and subjected on completion to test by water or smoke.

Unlike some items of repair, choked drains are a danger to health and the work must be carried out as expeditiously as possible and as far as possible complaints are dealt with on the same day they are made.

TOWARDS CLEAN AIR

It is often said that Man is his own worst enemy; he is certainly the greatest predator of all time. In regard to his environment no other creature has succeeded so completely, as has Man in fouling his environment so unpleasantly and offensively to the detriment, discomfort and risk to health of all. Many streams, rivers, lakes and shores around the coast show abundunt proof and evidence of sewage pollution and the continued population expansion merely aggravates and accentuates this. In a like manner, the air we breathe all day, every day, becomes grossly polluted with the smoke from coal burning in the home, from ineffieient engines of cars and lorries, from coal fired railways engines and from industry.

The effect of continually breathing polluted air is responsible for a considerable amount of chronic ill health. The extent of the suffering is terrible and the hospital cases, the patients of family doctors and those who die from air pollution may be compared with the tip of an iceberg in as much as the known cases represent only a fraction of the whole. The greatest paradox of all is that so much of this suffering and illness is completely unnecessary since much is due to the product of our own self-chosen environment. The tragedy of this merely highlights the misuse and wrongful application of a rich natural resource, an indigenous fuel, upon which fortunes have been made and which has, and still does, account for the employment of many thousands, a fuel which when used in its natural state as in past years can rightly be called the scourge of Britain, a fuel which at its peak has been called King – "King Coal". Yes! coal has rightly been called King – but should not the crown and accolade be accorded to the Kingship of illness and death. The attractiveness of coal lies in its easy and free burning properties, its plentifulness, apparent comparative cheapness and the fact that its use has become inherent with many people. All fuel is priced according to heat content. There are several grades of coal varying from the cheapest which has the largest amount of ash and smallest amount of heat to the dearest which contains less ash. The cheapest coal is an illusion because modern smokeless solid fuels have a far greater heat output with far less ash and lower cost than ordinary domestic coal so that inherent use and comparative cheapness is invalid. Smokeless fuels are extremely plentiful and whilst the Gas Boards are not now manufacturing the quantities of fuel they did formerly the production of other types of smokeless fuel (solid) has increased considerably so that production is very much in excess of demand. The use of these fuels on a modern appliance results in easy lighting and easy use of fuel, greater efficiency and therefore the burning of less fuel for a greater amount of heat.

The progress of smoke control in Salford is most satisfactory. Nearly 43% of the City is covered by operative smoke control areas. Further orders are awaiting confirmation and others are in the process of being prepared. The remaining area amounts to about 40% of the City and consists principally of small, terraced houses throughout which are pockets of houses which are scheduled for clearance at some future date. The proposed clearance property is interspersed throughout the area and is surrounded by property not scheduled for clearance so that in effect they form islands. A further complication is that the number of houses to be demolished when compared with the rate of re-housing is such that to demolish these present unfit houses without any further addition will take more than twenty years.

It is in areas such as these that amelioration is most essential. To defer action until demolition is obviously negative and does not consider the health and well being of those residents. The solution seems to lie in the inclusion of these houses along with other houses within a smoke control area and excluding them only if the houses are to be demolished within a very limited period.

The effect of smoke control is shown in the figures for pollution by smoke and sulphur dioxide. The amount of smoke has been reduced by 39% and the sulphur dioxide by 24% when the figures for 1966 are compared with those for 1962.

Year	Smoke	Sulphur Dioxide
1962	377	331
1966	230	252

The above figures are based on the overall average for six Measurement Stations and are expressed in microgrammes per cubic metre of air.

The fact that burning raw coal on domestic grates results in the appalling waste of valuable products is not important, what is really important is the illness which naturally follows such coal burning. Smoke control areas attempt and will succeed in reducing this illness, simply by eliminating coal burning. The fuel merchants who wilfully supply coal to smoke control areas residents and those who purchase such fuel do not realise the extent to which they are harming themselves and the efforts to bring about a smoke free atmosphere. This comment does not refer to an occasional emergency purchase when stocks have run out and no other fuel is available. It refers to the deliberate misleading of the public as to the availability of solid smokeless fuel by a minority of merchants. The remedy here is for an immediate amendment of the Clean Air Act 1956 so that heavy penalties can be imposed upon offending merchants. Smoke control areas are being established rapidly and the time for such action is now. In many respects the Clean Air Act 1956 does not go sufficiently far and the failure to control the sale of coal is one of them. The National Coal Board cannot escape responsibility for the sale of coal in smoke control areas, since they are the supplying body for all merchants. It would be a simple enough matter when it is known that a merchant is deliberately offending in this way to prevent him obtaining supplies of coal so that he either complies or goes out of business. The N.C.B. is responsible to the Minister who must instruct that body accordingly. In a like manner, the Minister of Housing and Local Government must initiate the necessary action, speed up the implementation of smoke control areas, fix targets for completion for all authorities and make smoke control a duty instead of a power so as to ensure that clean air becomes a reality.

As the solid smokeless fuel producing plants expand, gas and electricity works are constructed and natural gas is exploited to the full, it would be desirable to have a total ban on the sale of raw coal to the domestic market so that with the exception of industrial coal the whole amount produced would be processed. Clean air is the heritage of all, there is no automatic right to pollute it.

INDUSTRIAL ODOURS

In the early days of clean air, public indignation was focused more on dirty shirts than on dirty lungs, and air pollution was regarded as more of a local nuisance than a national menace. In many of our industrial cities at this time the smoke pall was so heavy for so long, particularly during winter, that it is difficult to understand how people have ever tolerated it.

As the population expands and heating standards are raised more smoke and combustion products find their way into the atmosphere. From industry a host of gaseous and particle pollutants are emitted and industrial expansion merely increases the volume. More cars and road vehicles merely add to this.

The combination of these effluents tends to overload the capacity of the atmosphere to disperse them, with the consequent highly unpleasant and, at times of inversion, disastrous results. The problem of air pollution is not to be regarded as one of mere nuisance: it is an ubiquitous, insidious threat to health and welfare.

All the major trends of growth and development in our society contribute to worsening and aggravating the situation. Smoke control eliminates the visible pollutants arising from the combustion of coal but too little of this is being done, and this insufficiently quickly. Already more than ten years have passed since the Clean Air Act came into operation and still only a fraction of the country has been dealt with. The problem of odours is far more serious and noticeable in built up areas where there are many differing types of industrial premises. There is seldom any clear demarcation between industrial areas and those used for dwellings so that houses and factories intermingle.

The processes carried out in factories are many and varied, giving rise to odours differing only in intensity and offensiveness. Both the factory employees and the inhabitants of the surrounding areas have to endure the odours, relief being afforded by a change in wind direction or climatic conditions. Employees generally will accept the odours as being inevitable and synonymous with the process. The unfortunate residents generally tend to do likewise mainly because remedial action may be costly, may be difficult to solve technically, and the owners may be unwilling to take such action.

The assessment of an odour is an objective matter and the principal legal remedy possessed by local authorities is that contained in the Public Health Act, 1936. Such action is subject to the further limitations imposed by the defence of the best practicable means which is not merely confined to plant and equipment but also relates to what is practicable in terms of the resources of the offending party. The Public Health Act, 1936 is therefore virtually useless and action in the High Court for an injunction at Common Law would be prohibitive on the grounds of costs alone.

Legislation of 1936 is inadequate for the needs and standards of 1966. Clean air is not simply a question of the absence of smoke, it should also include the absence of offensive odours. It is apparent that there is rather more misplaced sympathy with industrial problems than is justified and the public should receive more consideration in these matters than is usually accorded.

Legislation to include effective control of fumes, vapours, gases, industrial odours, dusts, etc., which in any way impair public comfort and convenience is urgently needed.

CHIMNEY HEIGHTS

The re-development of cleared sites involves the erection of differing types of new buildings including domestic, commercial and public in order to provide for the needs of the new community. Such re-development, particularly when on a large scale provides an opportunity to replan for future generations, since the new buildings will remain for more than sixty years and probably nearer a hundred years. The architects and planners of these areas who are responsible for building design apparently are mainly concerned with securing a pleasing elevation. A pleasing elevation is most desirable but it is not the only factor to be considered. The chimney of a building is purely functional in purpose and it is obvious that the chimney height will not necessarily correspond with the building height. Freedom from nuisance and the health and well being of the users of the building and surrounding buildings are more important than the elevation. If the desired elevation is not attainable with the fuel proposed the remedy is not to lower the necessary chimney height and still use the proposed fuel, but to change to a more suitable fuel which will enable the construction of a chimney in keeping with the architect's proposals.

In connection with chimney heights, Crown premises and schools are exempt from the provisions of Section 10 of the Clean Air Act, 1956. As far as schools are concerned the exemption is because the plans are approved by the Department of Education and Science. This exempting clause of more than thirty years ago is not consistent with, or appropriate to, the intentions of the Clean Air Act, 1956. No government department is in a position to approve chimneys and boiler plants from a desk in Whitehall; it is foolish to exempt any new buildings whether they be schools, Crown buildings or any other type of building from obtaining approval as to the acceptability of the boiler plant or chimney.

NOISE CONTROL

In the year 1966, a noticeable increase in the number of complaints of noise was apparent and it is to be expected that the future will see an ever-increasing public awareness of noise.

Noise is a problem of great practical importance from medical, economic and legal aspects and is as undesirable a feature of city life as is air or water pollution. It can be defined as "sound which is undesired by the recipient".

Noise is therefore purely subjective and must involve people, and its effects on an individual depend on many features – his sensitivity, his health, his environment, etc. It follows that the assessment of an alleged nuisance is complex. Clearly, in most cases assessment must depend on the reactions of a section of the public rather than that of an individual.

Noise control or the technology of obtaining an acceptable noise environment, has many applications. Town planners, architects and engineers give careful consideration to the problem in the positioning of highways,

noisy industry and buildings where quiet is desirable and in the incorporation of sound insulation. The public health administrator deals with the investigation, assessment and remedy of noise complaints.

The complaints received at the health department are normally where noise is alleged to interfere with sleep or pleasure or work.

Legally, noise can be an offence against statute or it may be an offence at Common Law. The Noise Abatement Act of 1960 states that noise or vibrations which are a nuisance shall be a statutory nuisance for the purpose of Part III of the Public Health Act, 1936

Examples of complaints dealt with :

(i) Noise from a wholesale newspaper depot

Complaints were received from people residing near the depot of noise caused by the delivery and sorting of newspapers in the early hours of the morning. The complainants alleged that their sleep was interfered with by the unnecessary slamming of car doors, the throwing of bundles of newspapers from lorries, and the revving of vehicle engines.

Observations were carried out on three occasions during the times of deliveries and the complaints were considered valid.

The secretary of the parent company was immediately notified along with the depot manager and their co-operation resulted in an immediate cessation of the nuisance.

(ii) Noise from light engineering works

The establishment of a light engineering works in a building previously occupied by a laundry immediately resulted in complaints of noise from people residing in a nearby street, particularly from two night workers.

Operations at the works included the hammering of metal fabrications and were of necessity, noisy, but occurred intermittently and during the day only.

Enquiries in the same street and neighbourhood indicated a mixed reaction and most people considered that the engineering operation did not unduly annoy them.

The management co-operated but complete suppression of noise was not possible having regard to operational and economic considerations. Taking into account these facts together with the conflicting community reaction it was felt that further action was impracticable.

FOOD HYGIENE

A major effort has been made this year to initiate improvements in the hygienic standards of mobile shops, delivery vehicles and market stalls.

It has long been a source of concern that standards of hygiene are generally lower in mobile food trades than in food premises. An impetus has been given to efforts to bring about improvements by the Food Hygiene (Market Stalls and Delivery Vehicles) Regulations, 1966. These regulations were published in June, 1966 with an operative date of 1st January, 1967. The changes made by the regulations are far-reaching, and go a long way to meeting the criticism of traders in food premises, who for many years have complained about the less onerous legal standards which mobile traders formerly had to observe.

In order to help traders, circular letters have been sent out to all traders known to be affected by the regulations with details of the new requirements. Traders operating in the Salford area were invited to visit the Health Department to see a display of equipment and also to discuss any practical problems.

Actual enforcement will of course not commence until 1968, but it is hoped that the advice and information given out this year will enable traders to comply with the minimum of delay.

Routine visiting of food premises has as usual produced improvements in the majority of cases by informal agreement. In two cases, however, frequent visits and warning letters failed to produce compliance and legal proceedings were therefore instituted. The following is a summary of the facts:

Case No. 1:

Summonses were issued against the occupier of premises used as a bake-house and confectioners shop, for contraventions of the Food Hygiene (General) Regulations, 1960. The contraventions were that the premises were in an insanitary state, contrary to regulation 5, and that the equipment was not clean, contrary to regulation 6.

Although repeated requests had been made to the occupier to improve standards a Public Health Inspector visited in July, 1966 and found it necessary to arrange for the immediate destruction of substantial quantities of stock because of contamination by dirt and mice droppings. Shelves and cupboards were found to be littered with mice droppings, dirt and stale cakes. The floors were covered with a layer of dirt which in places was more than an inch thick and the equipment was in an insanitary condition. One of the scoops was found to be rusty and to have mice droppings adhering to it. Because of the extreme nature of the contraventions, samples of the dirt and mice droppings were produced in court.

The defendant pleaded guilty and a fine of £100 was imposed.

Case No. 2:

Summonses were issued against the occupier of a restaurant for contraventions of the Food Hygiene (General) Regulations, 1960.

The premises were found to be insanitary and accumulations of refuse, cigarette ends, mouldy food etc., were found in various parts of the premises. In one of the food storage rooms a double bed was found, which was obviously in regular use for sleeping purposes.

The defendant pleaded guilty and a fine of £14 was imposed.

MEAT INSPECTION

CHELTENHAM STREET SLAUGHTERHOUSE

Manchester Meats Ltd., a company formed by three Manchester meat wholesalers, officially opened their slaughterhouse on Monday, 27th June, 1966, throughput subsequently building up to a pre-Christmas peak of 83 beasts and 1,632 sheep.

The Meat Inspection Regulations, 1963 give the local authority power to make charges in respect of Meat Inspection. The charges which are determined by the local authority shall not exceed:

(a) 2/6d. for each bovine animal,

(b) 9d. for each calf or pig,

(c) 6d for each sheep, lamb or goat.

As is common with the majority of other local authorities in Lancashire, Salford impose the maximum charges.

The Meat Inspection (Amendment) Regulations, 1966 provide local authorities with the power to exercise control over the hours of slaughter, the intention being to secure effective inspection of the animals slaughtered.

In pursuance of these regulations, Salford Corporation has fixed the following hours of slaughter:

Monday to Friday	7 a.m. – 7 p.m.
Saturday	7 a.m. – 12 noon
Sunday	No slaughtering

In practice these arrangements have been found satisfactory.

The Slaughter of Animals Act, 1958 is an act which provides for the humane slaughter of animals. During the year an employee of Manchester Meats Ltd., was found guilty of acting in contravention of sections 1 and 3 of the above Act in that :–

(a) he stunned two animals otherwise than by means of a mechanically operated instrument or an instrument for stunning by means of electricity,

(b) he stunned two animals whilst not being a licensed slaughterman.

The total fine was £60, a heavy fine in common with most animal cruelty offences.

Revenue, as provided by charges for Meat Inspection, was as follows :–

	£	s.	d.
2,729 bovines @ 2/6d.	341	2	6
31 calves @ 9d.	1	3	3
38,516 sheep @ 6d.	962	18	0
Total Revenue	1,305	3	9

Carcases Inspected and Meat Condemned within the District

	Bovines	Calves/ Pigs	Sheep/ Lambs
Number killed	2,729	31	38,516
Number inspected	2,729	31	38,516
All diseases except Cysticercus Bovis :–			
(a) whole carcases condemned	4	–	51
(b) carcase of which some part or organ was condemned	16	–	68
Cysticercus Bovis :–			
(a) Carcases of which some part or organ was condemned	9	–	–
(b) Carcases submitted to treatment by refrigeration	9	–	–
(c) Generalised and totally condemned	–	–	–

Weight of Meat and Offal Rejected from Animals Slaughtered

	Tons	Cwts.	Qtrs.	Lbs.
Full carcases	1	11	3	15
Part carcases		13	1	20
Offal	6	16	3	15
	9	2	0	22

Weight of Meat and Poultry Rejected, Not Slaughtered on the Premises

	Tons	Cwts.	Qtrs.	Lbs.
Frozen Meat, etc.	1	8	2	17
Chickens/Rabbits		2	0	10
Total	1	10	2	27

SAMPLING UNDER THE FOOD AND DRUGS ACT, 1955

745 samples were taken during the year and submitted to the City Analyst's Department for examination under the Food and Drugs Act, 1955. Details of these samples and the results of the analysis are shown in the City Analyst section of this Report.

The above total includes 299 milk samples taken for fat and non-fatty solids content. These were purchased from a wide variety of distribution points throughout the City, including hospitals, canteens, shops, vending machines, dairies and dairy vehicles. Also included are 23 samples of Drugs which were subjected to a chemical analysis by the City Analyst.

A large number of complaints regarding foodstuffs purchased in the City were received during the year from members of the public. The majority of these were submitted for examination to the City Analyst.

The complaints consisted of moulds, sourness, iron deposits (tinned meat) and a wide range of foreign bodies including plastic, tobacco, metal, wood, string, wire and various insects. All complaints were investigated and the appropriate action taken.

There were 2 prosecutions during the year under Section 2 of the Food and Drugs Act, 1955 and one under section 6 of the same Act :–

(1) A complaint was received that a marshmallow biscuit, purchased in the City contained tobacco and part of a cigarette paper.

The biscuit manufacturers concerned pleaded guilty and were given an absolute discharge.

(2) A quantity of sausage rolls was purchased in the City in a mouldy condition.

A fine of £20 was imposed on the manufacturers who pleaded guilty.

Legal proceedings were taken against the manufacturers of a baby food. This was in respect of a national advertisement about the nutritional value of a type of baby food which was thought to be misleading contra to section 6 of the Food and Drugs Act, 1955.

The case was dismissed and 200 guineas costs were awarded against the Corporation.

WATER SUPPLY SAMPLING

As a result of various complaints, 26 water samples were taken from mains supplies and were submitted for both chemical and bacteriological examination. The majority of the complaints were caused by silt in the pipes being disturbed and causing a brown discolouration in the water. These were referred to the Manchester Corporation Waterworks, who took the appropriate action (i.e. flushing out the main water supply pipe).

A large number of complaints were received from the Broughton Area during one period. Cyclops (i.e. a small shrimp-like insect) were abundant in the cold water supply. Eventually the waterworks department transferred the supply to another source and treatment was carried out on the service reservoir concerned.

SWIMMING BATH WATERS

Routine visits were made to each of the 4 Public Baths and the 3 School Baths.

224 samples were taken both for chemical and bacteriological examinations. Copies of all results are sent to the Baths Superintendent.

BACTERIOLOGICAL SAMPLING OF FOODSTUFFS

Ice Cream

59 samples of ice cream were taken from retail points in the City and subjected to bacteriological examination, with the following results :–

Number of samples	Grade
43	1
7	2
7	3
2	4

Inspections were made at manufacturers' premises and retail vehicles. Investigations and advice given in the cases of the 9 unsatisfactory samples shown above.

Milk

Of the 281 samples taken for bacteriological examination, 3 failed the Methylene Blue test. Investigations were carried out re the unsatisfactory samples and advice given to the Dairies concerned.

Desiccated Coconut

The desiccated coconut pasteurisation plant was inspected at regular intervals during the year. 218 samples were taken and submitted for salmonellae and coliform examination.

Salmonellae were absent in all samples. A small number of samples were found to contain faecal coliform organisms and the batches concerned were re-pasteurised.

Liquid Egg

55 samples were taken during the year and all were found to be satisfactory.

HAIRDRESSERS AND BARBERS

During the course of this year, applications for registration have been have been received in respect of 15 premises. Registration has been granted in each case after an inspection to ensure compliance with the Byelaws.

In the case of existing premises, a survey has been carried out in association with the survey under the Offices, Shops and Railway Premises Act. In the majority of cases, compliance with the byelaws has been achieved informally.

This year is notable however in that for the first time it has been necessary to institute legal proceedings against a hairdresser. The charges were dirty floors, allowing refuse to accumulate, dirty equipment and failing to maintain the water closet. The magistrate imposed a fine of £9.

PET ANIMALS ACT, 1951

The number of pet shops, has been further reduced by slum clearance programmes, and there are now only 13 such shops in the City.

All the premises are licensed annually and regular inspections are carried out in collaboration with the R.S.P.C.A. Compliance with the Act has been achieved by informal action.

ANIMAL BOARDING ESTABLISHMENTS ACT, 1963

Only one licence for the boarding of dogs and cats has been issued this year and this was in respect of premises occupied by the R.S.P.C.A. In one other case the condition of the premises has given rise to concern and the question of licensing is to be reviewed in the coming year.

SHOPS ACTS 1950/1965

The new rules controlling early closing days have been well received, although most shops seem to be adhering to the traditional Wednesday early closing day. The freedom to choose any day for early closing has been mainly taken advantage of by ladies' hairdressers, who were previously bound to observe Wednesday or Saturday. A substantial number of hairdressers now close on Mondays, thereby allowing them to provide a service on Wednesday afternoons.

A few disputes have occurred during the year between traders about alleged Sunday trading contravention. It has been found possible to settle all problems this year without recourse to legal proceedings.

OFFICES, SHOPS AND RAILWAY PREMISES ACT, 1963

Registration of Premises

The registration of existing premises having been completed, the problem remaining is to keep pace with the surprising number of changes which occur. Changes are brought about by re-development, changes of occupation and variations from time to time in premises included under section 2, as family businesses.

In theory, it should be a simple matter to keep registers up to date, because employers are required to notify the enforcing authority when they begin to employ staff in premises subject to the Act. In practice however, very few employers are doing this of their own volition. It is surprising that even large organisations, who generally did register premises at the commencement date of the act, are not generally notifying when new premises are opened.

This problem has been dealt with by careful liaison with the City Engineer's Town Planning Section, in so far as new premises are concerned. In existing premises the problem is more difficult because frequently planning permission is not required and vigilant observation by inspectors has to be relied upon. In this way, 71 new registrations have been discovered during the year.

Inspection of Premises

Since the commencement of the Act, approximately 70% of the premises originally registered have been given a general inspection. It is hoped to complete the remaining premises in the coming year.

One of the factors which has been found to be very time consuming, is the number of additional visits which are often necessary to obtain completion of the requirements. It will be seen from Table 'B' that on average something like three visits per premises, have been necessary to obtain completion. Many of these additional visits have of course been for the purpose of advice and information. In some cases however, there is a tendency for employers to delay action until pressed further. In one case where legal proceedings have been found necessary, no fewer than fourteen (14) visits were made by inspectors in an attempt to secure compliance.

Cleanliness

In the majority of the premises, reasonable standards have been found, except perhaps in little used parts of the premises such as cellars, stock-rooms, etc. In a small proportion of cases however, serious deficiencies have been found; in three such cases it has been necessary to institute legal proceedings. In all of these cases however, it was decided to proceed under other legislation, although proceedings could equally have been taken under the Offices, Shops and Railway Premises Act. Other legislation was used principally because it has been found that magistrates deal more firmly with contraventions which involve risk to the public, than where the prejudice is only to staff welfare.

The first case was during May 1966 and concerned a ladies' hairdressing salon. The question of cleanliness was dealt with under the Byelaws as to Hairdressers and a fine of £4 was imposed.

During July 1966 a prosecution was instituted against the occupier of premises used partly as a bakehouse and partly as a confectioner's shop. These premises were in an insanitary and verminous state and a fine of £100 was imposed for contravention of the Food Hygiene (General) Regulations 1960.

A restaurant was dealt with during July 1966 and a fine of £12 was imposed for insanitary conditions which were contraventions of the Food Hygiene (General) Regulations 1960.

Overcrowding

Cases of overcrowding have rarely been found, possibly because the standard in section 5(2) is on the low side.

Temperature

Heating deficiencies have been the most frequent subject of complaints received from staff, and all complaints have been dealt with satisfactorily.

On routine visits, heating deficiencies have been commonly found in shops and warehouses but rarely in offices. A great deal of work has been done on this and in many cases substantial improvements have resulted.

In a few cases employers have resisted suggested improvements on the grounds of practicability and exemptions under section 6(3).

Problems of practicability are frequently found in large warehouses, particularly where the proportion of staff is very low in relation to the size of the room. However, many enlightened employers already have practicable systems in such circumstances and it is hoped by advice and information to produce improvements where necessary.

Legal proceedings have not yet been resorted to under section 6, but negotiations are in progress in a number of cases which are as yet unresolved.

Ventilation

Ventilation by natural means has generally been accepted, except in premises with special problems. In general, mechanical ventilation has been requested in betting shops, ladies' hairdressers, public houses and food premises where cooking is carried on.

Lighting

In modern buildings the level of illumination has generally been found to be sufficient. It is remarkable however the number of new buildings where lighting fittings are not capable of being used to the best advantage, due to incorrect siting or fitting or to unsuitable switching arrangements.

A common example of this is offices where lighting fittings are switched in groups of two or more. It is frequently found that the fittings are switched at right angles to the window wall, rather than parallel to the window wall. In such circumstances, persons sitting at desks which are remote from the window wall, will inevitably have much less light than those near the windows (except at night). They may also suffer from glare. It is not appropriate to deal with such cases from a legal point of view, but advice has been given where necessary.

In older buildings lighting standards vary greatly. In some cases modern lighting systems are found which are equal to the standards found in the best of modern buildings. More commonly minimal improvements are made to achieve standards in the range 15 – 25 lumens per square foot at desk level.

Very low standards are occasionally found which curiously have not produced complaints by staff. In one particularly interesting case, two typists were found working in an office lighted to the standard of only 5 lumens per square foot at desk level. The lighting was almost entirely artificial, the window being small and remote from the working area. The typists were quite happy with the lighting and expressed surprise when the inspector said that improvement was necessary. The employer subsequently improved the lighting by providing a fluorescent fitting in addition to the existing filament lamp. Each light was separately switched and surprisingly it was found that in the first week one of the typists would turn out the fluorescent light on her arrival at the office. In subsequent weeks the reluctance of the staff to use the light gradually diminished until after about three months both lights were almost invariably in use.

Common parts of plurally occupied buildings are a particular problem, as owners are frequently unwilling to provide anything more than minimal standards on such places as staircases and passages. Improvements have been obtained in a number of cases.

Lighting tends to be neglected in water closets, particularly where the water closet is situated externally, in yards and passages. Where possible electric lighting has been required in such cases.

Sanitary Conveniences and Washing Facilities

Adequacy of provision has rarely been found to be a problem. Lack of cleanliness, infrequency of decoration and poor maintenance generally are common problems. In two cases during the last year, legal proceedings have been taken for defective water closets and another case is pending.

With the exception of food shops, about 50% of shops have been found not to be provided with a hot water supply. In most cases hot water facilities have been made available with the exception of one case where legal proceedings are pending.

Eating Facilities (shops only)

The standard of facilities varies greatly and practical difficulties are

sometimes found where small premises are converted into supermarkets in such a way that space is at a premium. In cases where facilities are not available it has been required that employees have at least one hour for lunch as provided in the Shops Act 1950.

Floors, Passages and Stairs

A surprising number of staircases have been found without handrails and improvements have resulted in the majority of cases. Employers have readily agreed to provide handrails in most cases but resistance has been found in a few cases where staircases are little used. Particularly troublesome are cellar staircases, where the cellar is not used except by meter readers. In every such case employers have been advised to provide handrails on every staircase as there is risk of accidents on any staircase which may be used, however infrequently.

First Aid

A leaflet has been produced describing the facilities necessary and these are given out by inspectors wherever unsatisfactory facilities are found.

A common problem is that the first aid boxes sold for the purpose of the Offices, Shops and Railway Premises Act 1963, do not comply with the Food Hygiene (General) Regulations, 1960. This is not always understood and occupiers frequently have to be advised to obtain the additional requisites necessary.

Safety of Machinery

The most common problem is the guarding of food slicers and particularly the gravity feed types. Manufacturers are now producing a variety of guards many of which have proved satisfactory. In a few cases however, guards have been designed which have not been acceptable to staff, and in such cases it is commonly found that operators remove the guard from the machine.

A great deal of work has been done on this and in conjunction with the Engineering branch of the Ministry of Labour, suggestions have been evolved for improving some of the guards which have proved to be troublesome. Employers having difficulty with the guarding of food slicers should contact the Local Authority (Health Department) for advice.

Lifts, hoists and teagle openings are frequently found and as far as possible similar standards as are enforceable under the Factory Acts are requested. The proposed regulations on this subject will be useful.

Accidents

Notifiable accidents this year have totalled 41 which is 4 more than last year. This year none of the accidents reported have been fatal, nor have any given rise to serious disability

Falls to Persons :

This was the most common cause, accounting for about 45%.

Handling Goods :

This was the second most common cause, accounting for about 35%.

Hand Tools :

About 15% were due to use of hand tools and in the majority of cases these accidents occurred in butchers' premises, frequently with young boys in training.

The remaining accidents were caused by such things as transport machinery, falling objects, etc. It is notable that machinery accidents are at a very low level, and that no accidents occurred on food slicers this year.

Accident investigations have been carried out wherever it has been felt likely to be useful and in general advice and information has been given. None of the accidents arose out of wilful contraventions of the act and legal proceedings have not therefore been taken as a result of any of the accident notifications.

Legal Proceedings

No. 1 Case :

Following a series of routine visits to a ladies' hairdressing salon proceedings were taken against the proprietor of the business. Information was laid under section 9(2) of the Offices, Shops and Railway Premises Act 1963.

The sanitary convenience was alleged to be not properly maintained because the window and window frame to the compartment were broken, the door had no handle and the water closet cistern had no chain. The compartment was not provided with artificial lighting, despite the fact that the premises opened during the hours of darkness.

The defendant pleaded not guilty on the grounds that he rarely visited the premises and had delegated responsibility for maintenance to his manager. The Stipendiary Magistrate found the case proved and imposed a fine of £5. At the same hearing three informations were laid for contraventions of the byelaws, for lack of cleanliness in the premises, and for dirty equipment.

No. 2 Case :

In September, 1966, the City Council authorised legal proceedings against the proprietor of a fuel storage depot, for contraventions of sections 9, 10 and the First Aid Order, 1964.

Informations were laid and court hearings were arranged for 11th

November, 1966, and 16th December, 1966, but on each occasion it proved to be impossible to serve the summons because of evasive action taken by the defendant. It is hoped to proceed during January, 1967.

A close liaison with the H.M. District Inspector of Factories has been maintained on this case, because from time to time the premises have been used also for a factory process on intermittent basis. It is now clear from a long series of visits by both the Public Health Inspector and the Factories Inspector, that the factory process has been virtually discontinued and that the premises are clearly subject to the Offices, Shops and Railway Premises Act, 1963.

Exemptions

It will be noted from Table 'D' that exemption from section 9 of the Act has been granted in one case. This is the only application that has ever been made and the circumstances are as follows.

Four male staff and three female staff are employed to work in a small branch bank. The premises are provided with a sanitary convenience which is in every way suitable and well-maintained, except that both sexes have to share the use of the convenience. The provision of separate conveniences for the sexes would be difficult for space and structural reasons, and it was claimed that the cost would be in the region of £400. The applicant suggested that this was unreasonable because of a proposal to demolish the premises for motorway construction purposes in the foreseeable future.

Discreet enquiries were made and it was found that the staff did not object to the application, which was approved by the City Council.

Conclusion

Although much work remains to be done, the enforcement arrangements are working well. A high standard of co-ordination has been established with the District Inspector of Factories and with surrounding local authorities and the excellent circulars issued by the Ministry of Labour have been a great help in ensuring uniformity.

As far as possible premises which are known to be unsatisfactory have been inspected as a matter of priority. Any employee who feels that an inspection is required, at his place of work, however is invited to apply to the Health Department. All complaints have been and will be dealt with promptly.

APPENDIX – OFFICES, SHOPS AND RAILWAY PREMISES ACT 1963

Table A – Registrations and General Inspections

Class of premises	Number of premises registered during the year	Total number of registered premises at end of year	Number of registered premises receiving a general inspection during the year
(1)	(2)	(3)	(4)
Offices	22	449	60
Retail shops	34	913	175
Wholesale shops, warehouses	9	104	32
Catering establishments open to the public, canteens	18	261	66
Fuel Storage depots	–	14	2
Totals	83	1,741	335

Table B – Number of visits of all kinds by Inspectors to Registered Premises

1,101

Table C – Analysis of Persons Employed in Registered Premises by Workplace

Class of Workplace		No. of Persons employed
(1)		(2)
Offices		3,831
Retail Shops		2,861
Wholesale departments, warehouses		1,270
Catering establishments open to the public		1,630
Canteens		47
Fuel storage depots		110
	Total	9,749
	Total Males	4,982
	Total Females	4,767

TABLE D – Exemptions

Part III Sanitary Conveniences (sec. 9)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Offices	1	1	Nil	Nil	Nil	Nil
Retail Shops						
Wholesale shops, warehouses						
Catering establishments open to the public, canteens						
Fuel storage depots						

TABLE E – Prosecutions

Prosecutions instituted of which the hearing was completed in 1966

Section of Act or title of regulations	Number of persons or companies prosecuted	Number of Informations laid	Number of Informations leading to conviction
(1)	(2)	(3)	(4)
9	1	1	1

No. of complaints (or summary applications) made under Section 22 – Nil.

No. of interim orders granted – Nil

Table F – Inspectors

No. of Inspectors appointed under section 52(1) or 5 of the Act	1
No. of other staff employed for most of their time on work in connection with the Act	1

PEST CONTROL

Rodent Control

A staff of one foreman and five operators ensure as far as practicable that the City is kept free from rats and mice.

(a) Surface Investigations and Treatment

Rats

During the year, 482 rat complaints were investigated and only 132 complaints warranted action and treatment. In 22 cases the trouble was traced to defective drains and in all cases the drains were repaired or sealed-off on the service of Preliminary Notices. The co-operation between the landlords, contractors and the staff has been maintained again this year as no Statutory Notices had to be issued.

Some 350 complaints investigated by the operators were found to be "false alarms", one complaint of a large rat under a garden shed in a residential part of Salford was investigated and a feral mink was captured and killed. The animal was dispatched to the Divisional Pest Officer of the Ministry of Agriculture, Fisheries and Food for his observations as wild mink had been reported in different parts of Lancashire. Other "false alarms" turned out to be rabbits, hedgehogs, wild cats and guinea pigs.

A free service is given to owners and occupiers of dwelling houses and a charge of 15/- per hour inclusive of material is made to occupiers of business premises.

Mice

A total of 612 visits were made to premises and 549 cases warranted action by the operators. Occupiers of dwelling houses are offered pre-packed boxes of 'Warfarin' at 9d. per box and occupiers of business premises are charged 15/- per hour inclusive of material. The pre-packed boxes of Warfarin can also be purchased at the Enquiry counter and a total of 1,815 packets were sold last year.

During the past few months the operators have been using a new bait (containing 4% alpha-chloralose as its active ingredient) in cases where complaints were received of mice "thriving" on Warfarin. This new rodenticidal bait is a narcotic which slows down respiration, reduces blood pressure and lowers body temperature so rapidly that death occurs.

Excellent results have been recorded and it is hoped to use more of it during the coming year.

At the present time this new rodenticide has only been given a provisional commercial clearance for sale to local authorities by the Advisory Committee on Pesticides and other Toxic Chemicals and it is hoped that the Committee will in the near future give it a clearance for sale to the public.

(b) Sewer Treatment

The three-man team were once again able to carry out 3 complete treatments in the sewer system within the City. They inspected, baited and recorded 3,064 manholes using .025% Warfarin containing P.M.P. on each. The maintenance uses the "bag baiting" method devised by the staff and now recognised by the Ministry of Agriculture, Fisheries and Food as a method to treat sewers.

The following table gives a summary of the year's work :–

Section of system treated	Total No. of manholes in the system	No. of manholes treated	No. of manholes showing takes	Weight of bait in ounces
44th Maintenance from 17/11/65 – 8/3/66				
Salford 1/13	881	850	70	213
Broughton 1/11	733	716	22	79
Pendleton 1/17	1,450	1,412	26	70
Total	3,064	2,978	118	362
45th Maintenance from 9/3/66 – 28/6/66				
Salford 1/13	876	859	48	130
Broughton 1/11	733	718	26	69
Pendleton 1/17	1,445	1,414	18	51
Total	3,054	2,991	92	250
46th Maintenance from 29/6/66 – 26/10/66				
Salford 1/13	869	852	70	183
Broughton 1/11	733	719	42	107
Pendleton 1/17	1,439	1,407	32	97
Total	3,041	2,978	144	387

Feral Pigeons

A publicity campaign was started in November, 1965 by a strong letter in the local press pointing out the dangers such as damage to property, nuisance from pigeons establishing themselves in roof spaces, attracting mice, rats and insects and dangers from pathogenic organisms found in pigeon droppings which cause harm to the health of susceptible people. The local evening paper also ran an article based on the letter, and this was followed up by the National press; B.B.C., radio and television and I.T.V. Interviews on the radio and television helped to launch the campaign on a sound footing. This free publicity was followed by visits to all types of shops within the City, requesting shopkeepers to display notices in their shops asking the public not to feed pigeons.

The publicity brought a flood of complaints which were investigated. Offending occupiers were approached and requested not to feed the birds and in most cases the feeding stopped.

In cases where resistance was found, portable traps were placed as near as possible to the feeding sites and daily visits were made to feed and water the trapped birds, the traps being emptied once or twice during the week. During the year 1,642 pigeons have been trapped and humanely destroyed at the local R.S.P.C.A. centre.

Experiments are being carried out at present with cartridges of gelatinous substance which is extruded in a narrow strip from a caulking gun on to surfaces where the pigeons perch and roost. This gel gives the birds a feeling of insecurity as they land and makes them fly elsewhere.

The front of the Town Hall was treated and within the weeks which followed no pigeons landed on any of the treated surfaces, thus for the first time in years the approach steps were free from droppings.

It is hoped to extend this service to the public during the forthcoming year.

Disinfestation Service

The work of the disinfestors is carried out by 2 full-time operators, using a light van to convey them and their equipment from job to job.

A nominal charge of 7/- per room is made to occupiers of dwelling houses for any type of treatment. The occupiers of business premises are charged on the basis of time and material used. In cases of hardship, a free service is given.

The following table shows the volume of work carried out.

Insects Attacked	No. of operations in 1966	No. of operations in 1965
Bedbugs	210	190
Cockroaches	423	492
Wood-boring beetles	2	2
Flies	11	28
Mites	4	–
Golden Spider beetles	21	17
Wasps	11	21
Fleas	14	12
Ants	2	6
Moths	1	1
Lice	11	6
Larder beetles	94	50
Silver Fish	–	1
Total	804	826

In addition to the 804 treatments for specific infestation, 1,236 slum clearance dwelling houses and furniture were sprayed with insecticides prior to the removal of the families to new Corporation houses, an increase of 68 jobs on last year.

Also, 39 visits were made to hospitals to treat for cockroaches and steam flies.

1,348 packets of beetle powder were sold and 79 packets issued to Corporation tenants at the inquiry counter.

Disinfection Service

The Disinfection Station is situated in the grounds of Ladywell Hospital and is manned by two full time operators.

Normal routine work was interrupted in July when a case of smallpox was reported in the City. Full emergency measures were taken. The two disinfestators and the two disinfectors were vaccinated and issued with protective clothing and together with the ambulance staff were on stand-by duty.

All bedding and clothing of suspected and confirmed cases were removed to the Disinfection Station and subjected to steam disinfection as soon as the patient was evacuated to the isolation hospital. The house and contents were then disinfected, using a solution of sodium hypochlorite in an electric fogging machine. The ambulance and the disinfestation van were also treated on return from each case and all blankets and protective clothing steam disinfected. During the emergency, 46 lots of bedding and clothing were steam disinfected.

The following table shows the volume of work carried out during the year.

		Beds	Bundles of clothing
Infected bedding and clothing		20	67
Verminous bedding and clothing		8	12
Clothes of patients admitted to hospital		–	41
Beds and bedding from	Ladywell Hospital	251	384
	Salford Royal Hospital	2	22
	Hope Hospital	9	68
	Pendlebury Childrens' Hospital	–	7
	Port Health Authority	2	2
	Urmston Health Department	1	2
	Swinton Health Department	2	4
	Stretford Health Department	1	1
Sterilising apparatus and dressing drums		915 drums	
Blankets from Ambulance Services –	Salford	254	
	Urmston	10	
	Stretford	45	
	Eccles	16	
Rags for export		12 bales	

In addition to the above steam disinfection the following disinfections were carried out by spraying with formaldehyde.

Ladywell Hospital	431 beds
Salford Royal Hospital	16 beds and 10 sidewards
Ambulances	50
Ships' cabins	3
Hospital Library Books	420
Dwelling Houses	12

12 demonstrations for students were also arranged.

STATISTICS

Visits by Public Health Inspectors

Sanitary Defects	14,991
Houses in Multiple Occupation	310
Housing Act Inspections	58
Clearance Areas	6,975
Improvement Grants	3,457
Advance on Mortgages	160
Housing Applications	1,155
Factories	891
Schools	22
Canteens (Factory and School)	123
Caravans	28
Public Houses	179
Places of Entertainment	72
Boarding Houses and Hotels	13
Cafes, Snackbars, etc.	252
Food Shops	1,691
Food Stalls and Vehicles	319
Food Preparing Premises	133
Food Poisoning	103
Infectious Diseases	269
Offices, Shops and Railway Premises Act	1,155
Shops Act	128
Food Hygiene	297
Merchandise Marks Act	434
Food and Drugs Act Samples	165
Unsound Food	474
Diaries	101
Milk Samples	148
Ice Cream Samples	73
Swimming Bath Water Samples (including Water Supply samples)	259
Pharmacy and Poisons Act	15
Rag, Flock and other Filling Materials Act	2
Fertilisers and Feeding Stuffs Act	2
Slaughterhouse	864
Hen Slaughterhouse	56
Cattle Sidings	6

Piggeries	13
Fowl Pest	1
Pet Shops	34
Animal Boarding Establishments	6
Hairdressers Shops	170
Noise Nuisance	77
Air Raid Shelters	41
Rodent Control	836
Pest Act	153
Pigeons	240
Smoke Control Areas	14,909
Smoke Observations	72
Vehicle Exhaust	12
Totals	51,944
Calls – No admittance	5,498
Letters	8,778

Complaints and Notices Issued under the Public Health Acts

Number of complaints received	8,428
Statutory Notices Issued	3,996
Informal Notices Issued	1,760
Statutory Notices Abated	3,110
Informal Notices Abated	788

List of Samples Taken

Food and Drugs (other than Milk)	391
Milk for Phosphatase Test	163
Milk for Methylene Blue Test	163
Milk for Turbidity Test	118
Milk for Fats and Solids-not-Fats	299
Ice Cream	59
Fertiliser and Feeding Stuffs Act Samples	4
Water Supply Samples	26
Swimming Bath Water Samples	224
Rag Flock Samples	2
Miscellaneous Samples for Bacteriological Examination (including Desiccated Coconut, Cooked Meats, etc.)	240
Pasteurised Liquid Egg	55
Total	1,744

Results of Milk Samples

Test	Milk	No. Tested	Pass	Fail	% Fail
Methylene Blue	Untreated	1	1		
Methylene Blue	Pasteurised	163	160	3	1.8
Phosphatase	Pasteurised	163	163		
Turbidity	Sterilised	118	118		

Unsound Food Condemned

		Tons	Cwts.	lb
Meat	25,563 lbs	11	8	27
Fruit	2,842 ,,	1	3	66
Vegetables	336 ,,		3	0
Jam	297 ,,		2	73
Fish	227 ,,		2	3
Sausage	140 ,,		1	28
Fowl	26 ,,			26
Lard	83 ,,			83
Soup	6 ,,			6
Dried Eggs	114 ,,		1	2
Coconut	14 ,,			14
Ground Rice	7 ,,			7
Ground Almonds	5 ,,			5
Dried Milk	10 ,,			10
Gherkins	184 ,,		1	72
Creamed Rice	1 ,,			1
Golden Cube Paste	1,736 ,,		15	56
		14	0	31

Factories Act, 1961

(1) Inspections for purpose of provisions as to health :–

Premises	Number on Register	Number of		
		Inspections	Written Notices	Occupiers prosecuted
1. Factories in which sections 1, 2, 3, 4 and 6 are to be enforced by local authorities	8	1	1	–
2. Factories not included in (1) in which section 7 is enforced by the local authority	773	141	49	–
3. Other premises in which section 7 is enforced by the local authority (excluding out-workers premises)	43	4	4	–
Total	824	146	54	–

(2) Cases in which defects were found

Particulars	Number of cases in which defects were found			
	Found	Remedied	Referred to H.M. Inspector	Referred by H.M. Inspector
Want of cleanliness (S.1)	–	–	–	–
Overcrowding (S.2)	–	–	–	–
Unreasonable temperature (S.3)	1	1	–	2
Inadequate ventilation (S.4)	–	–	–	–
Ineffective drainage of floors (S.6)	–	–	–	–
Sanitary Conveniences (S.7)				
(a) Insufficient	–	–	–	2
(b) Unsuitable or defective	47	27	–	12
(c) Not separate for sexes	1	1	–	–
Other offences against the Act (not including offences relating to out-workers)	–	–	–	–
Total	49	29	–	16

(3) Outworkers (Section 133)

Number of out-workers in August list (required by Section 110(1)) 126

Nature of work: Making, etc. of wearing apparel. 126

CITY LABORATORY

The City Laboratory provides an analytical service for the City of Salford and also for the neighbouring authorities of Eccles, Stretford, Sale, Urmston and Worsley. For sampling purposes the six authorities co-operate closely and participate in schemes for the integrated routine sampling of both foods and drugs.

The total number of analyses and tests from all sources was 3,469 and may be classified as follows :–

	City of Salford	Borough of Eccles	Borough of Stretford	Borough of Sale	Urban District of Urmston	Urban District of Worsley
Food and Drugs Act Samples	613	137	148	130	169	83
Pesticide Survey Samples	6	3	–	–	–	–
Pasteurised Liquid Egg	58	–	–	–	–	–
Fertilisers & Feeding Stuffs	4	–	–	–	–	–
Miscellaneous Samples						
Swimming bath waters	221	28	11	–	6	–
Contract Samples	160	–	–	–	–	–
Pharmacy & Poisons Act Samples	–	–	–	–	–	–
Others	72	–	3	2	2	–
Atmospheric Pollution Tests	1,613	–	–	–	–	–
	2,747	168	162	132	177	83

Total = 3,469

In respect of the work carried out for the additional five authorities mentioned above fees of £2,355 0s. 0d. were received by Salford Corporation.

New Food and Drugs Legislation etc., during 1966

The Salad Cream Regulations, 1966 re-enact with amendments, the Salad Cream Order 1945. Compositional standards are specified for Salad Cream, Mayonnaise and Salad dressing.

The Mineral Hydrocarbons in Food Regulations 1966 replace and amend the 1964 Regulations. Amendments include a new analytical test to demonstrate the absence of polynuclear hydrocarbons in the waxes used in chewing compounds, amended specifications for mineral hydrocarbons, and permit the presence of mineral hydrocarbons in cheese only in the rind of whole processed cheese.

The Butter Regulations 1966 specify compositional standards for butter and also contain provisions for the labelling and advertising of butter.

The Colouring Matter in Food Regulations 1966 withdraw six coal-tar colours from the list of permitted colours and add one to it. There are now 25 permitted coal-tar colours. Labelling requirements and standards of purity are also laid down.

The Antioxidants in Food Regulations 1966 re-enact with amendments the 1958 Regulations. Antioxidants are now prohibited in food for babies and young children; specifications of purity are now laid down for the permitted antioxidants and ethoxyquin is allowed on apples and pears.

Regulations amending the Cheese Regulations 1965 and the Skimmed Milk with Non-Milk Fat Regulations 1960 were also made during 1966.

Proposals for Regulations were introduced and circulated for comment on:

Solvents in Food,

Fish and Meat Spreadable Products,

Amendments to the Cheese Regulations, 1965.

In addition, Reports on Solvents and on Cyclamates by the Food Additives and Contaminants Committee and a Report by the Food Standards Committee on Claims and Misleading Descriptions were published.

Food and Drug Samples

The total number of samples taken under the Food and Drugs Act during the year from all sources was 1,280. This figure represents an overall sampling rate of 3.25 samples per 1,000 population per year. The individual rates for the different authorities are given in Table 1.

TABLE 1

Sampling Rates 1966

Authority	No. of Samples per 1,000 population per year
County Borough of Salford	4.02
Borough of Eccles	3.19
Borough of Stretford	2.43
Borough of Sale	2.47
Urban District of Urmston	3.91
Urban District of Worsley	1.93

Pesticide Residues in Foodstuffs

There is much concern at present about the presence of pesticide residues in foodstuffs, particularly the organo-chlorine ones as these tend to accumulate in the body. Some countries have legal standards for the maximum amounts of pesticide residues allowed in foods. In this country, however, reliance is placed on the voluntary co-operation of the

farmer and grower etc., to use only approved products in the recommended way and by so doing ensure that the commodity will be satisfactory as regards pesticide residues. This applies mainly to direct treatment of foods with pesticides and cannot have any direct control when pesticide build-up occurs through the food chain, as for example in animal fats and milk products.

To find out whether foodstuffs are in fact being contaminated and to determine the extent of any contamination, a scheme has been prepared by the Association of Public Analysts and the Local Authorities Associations whereby a systematic survey covering the whole country could be undertaken. For the purpose of this National Survey of Pesticide Residues in Foodstuffs the country has been divided into seven zones. More than 200 authorities, including Salford, Eccles, Stretford, Sale, Urmston and Worsley are taking part in the survey and some 2,500 samples a year will be examined for pesticide residues. The latest analytical techniques will be used and these are capable of detecting and determining as little as one part of certain pesticides in ten thousand million parts of food. Most attention will be focussed on the chlorinated pesticides, such as D.D.T., gamma benzene hexachloride, dieldrin, but foods will also be examined for phosphorus pesticides and in some cases compounds of lead, arsenic and mercury.

The survey started in August, 1966 and is intended to run for two years initially.

In addition to the National Survey, the local authorities using the laboratory have organised their own local survey of foods for pesticide residues.

It is too soon to draw any definite conclusions from the results, but of the samples examined in this laboratory so far, about one-third have been found to contain traces of pesticide residues although none of them has been present in an excessive amount.

The work done for the City of Salford may be divided into four sections:– Food and Drugs; Fertilisers and Feeding Stuffs; Miscellaneous Samples and Air Pollution. Details are given in the following pages.

FOOD AND DRUGS

Table 2 shows the number of samples examined under the Food and Drugs Act 1955 and the irregular samples in each category.

TABLE 2

Samples examined under the Food and Drugs Act

Samples	Number examined	Number adulterated or irregular
Alcoholic Beverages—other than Spirits	2	Nil
Baby Foods	11	7
Baking Powder	5	1
Bread	4	2
Butter	5	Nil
Cereals and Cereal Products	4	Nil

Samples	Number examined	Number adulterated or irregular
Cheese and Cheese Products	5	Nil
Chocolate Confectionery	4	1
Coffee and Coffee Products	16	Nil
Drugs	23	2
Eggs – dried	2	2
Fat – other than butter or margarine	6	Nil
Fish Products – canned	11	1
Flour Confectionery – other than bread	5	3
Fruit – canned	5	1
Fruit – dried	2	1
Fruit – fresh	16	Nil
Fruit – pie	1	Nil
Fruit – juice	2	Nil
Ice cream	1	Nil
Margarine	8	Nil
Meat Products – canned	21	5
Meat Products – pies	5	3
Meat Products – sausages	9	1
Meat Products – others	16	4
Milk – for compositional analysis (ordinary)	245	Nil
Milk – for compositional analysis (Channel Islands)	52	Nil
Milk – evaporated	7	Nil
Milk – others	10	5
Milk – products	11	Nil
Pickles	1	Nil
Preservatives	1	Nil
Preserves	8	1
Puddings	4	Nil
Sauces	12	1
Soft Drinks	17	Nil
Soups	2	Nil
Spices, Condiments and Herbs	14	4
Spirits	5	Nil
Sugar	4	2
Table jellies – desserts	9	Nil
Vegetable Products – canned	9	1
Vegetable Products – dried	6	Nil
Vegetable Products – fresh	6	Nil
Vegetable Products – juice	1	Nil
TOTAL	613	48

Milk

The average composition of the milks analysed is given in Table 3, the corresponding figures for the previous five years being given for comparison.

TABLE 3

	1961	1962	1963	1964	1965	1966	Minimum Standard
All Milk (other than Channel Island)							
Fat %	3.61	3.57	3.58	3.55	3.56	3.51	3.00
Non-fatty Solids %	8.65	8.68	8.72	8.82	8.77	8.73	8.50
Total Solids %	12.26	12.25	12.30	12.37	12.33	12.24	
Channel Islands Milk							
Fat %	4.86	4.67	4.66	4.82	4.67	4.51	4.00
Non-fatty Solids %	9.14	9.21	9.20	9.40	9.26	9.16	8.50
Total Solids %	14.00	13.88	13.86	14.22	13.93	13.67	

Unsatisfactory Samples

The total number of food and drug samples examined during 1966 and found to be irregular was 48 and of these 34 were "complaints".

Table 4 shows the numbers and percentages of irregular samples in the different categories.

TABLE 4

Classification of Irregular Salford Samples

	Number of Samples	Number irregular	Percentage irregular
Total Food and Drug Samples including 'complaints'	613	48	7.8
Milks	297	–	–
Food and Drugs (other than milks) including 'complaints'	316	48	15.2
Food and Drugs excluding milks and 'complaints'	250	15	6.0
Food and Drugs including milks but not 'complaints'	547	14	2.6
'Complaint' samples	66	34	51.5

Details of the unsatisfactory foods and drugs are given in Table 5. In this table, numbers prefixed by the letter 'A' are formal samples, those by letter 'B' are informal samples and those suffixed by the letter 'C' are 'complaint' samples.

TABLE 5

Unsatisfactory Food and Drug Samples (other than milk)

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B3478/C	Luncheon Meat	A piece of blue plastic was embedded in one end of this roll of luncheon meat.	Producers interviewed.
B3514/C	Strained Chicken Noodle Dinner	Foreign object present in jar; identified as an empty puparium of a bluebottle.	Packers notified and cautioned.
B3535/C	Ham	Ham contaminated with phenolic compounds and copper salts.	Stock condemned.
B3510	Cabbage Borsht	Minor labelling irregularity.	Packers notified.
B3559/C	Baby Rice	The packet of baby cereal contained remains of a cigarette end.	Packers interviewed but no further action as it was suspected that this could have occurred after purchase.
B3597/C	Brown Sugar	Considerable amount of filth present also a yeast like growth.	Premises inspected. Remainder of stock condemned.
B3624/C	Brown Sugar	This was a further sample of B3597/C and it also contained filth and a yeast like growth.	Premises inspected. Remainder of stock condemned.
B3598/C	Dried Egg	Acid value of the oil extracted from the sample was considerably higher than is normal for edible oils, indicating that the egg had undergone some deterioration.	Stock destroyed.
B3647/C	Apricot halves	The insects present were identified as Queen of Black Ant (lasius fuliginosus).	Wholesalers notified.
B3571	Spirit of Sal Volatile	The sample was deficient in free ammonia.	Pharmacist interviewed.
B3609/C	Marshmallows	In the biscuit part of one partly eaten marshmallow was a wad of tobacco which appeared to have come from a cigarette end.	Legal Proceedings taken Plea of "Guilty". Absolute discharge.

Serial Number	Description	Nature of adulteration or irregularity	Remarks
A1322	Beef and Egg Noodles with Vegetables	The advertising clauses about the nutritional value of these baby foods were thought to be misleading.	Legal Proceedings taken under Section 6 of Food and Drugs Act. Case dismissed. 200 guineas costs awarded against Salford Corporation.
A1323	Beef and Egg Noodles with Vegetables		
A1324	Beef and Egg Noodles with Vegetables		
B3664	Dried Egg	Acid value of the oil considerably higher than normal.	Stock withdrawn.
B3665/C	Cherry Fruit Cake	Piece of dowelling rod embedded in the cake.	Warning letter sent to baker.
B3714/C	Chicken and Chips	Analysis indicated that the chicken had deteriorated to an extent sufficient to render it unpalatable.	Cafe inspected. Vendor interviewed.
B3732/C	Pork Luncheon Meat	Analysis indicated that this meat had also deteriorated.	Vendor interviewed.
B3777/C B3778/C	Milk	Milk sour on delivery.	Diary notified. Full investigation carried out in conjunction with diary.
B3795/C	Portion of Meat and Potato Pie	Contaminated with mould of the aspergillus group.	Representative interviewed and cautioned.
B3776	Lobster Fish Paste	Fish content lower than recommended level.	Further samples to be taken when available.
B3811/C	Sirloin Complaint	Tainted sufficiently to render unpalatable. This was caused by epoxyresin compounds which had been used on the floor of the freezing room.	Stocks condemned.
B3815/C	Corned Beef	Black discolouration due to the presence of excessive amounts of iron salts.	Packers notified. Stocks investigated.
B3818/C	Sausage	The unusual phenolic taint confirmed organoleptically but nothing could be detected chemically.	Trouble caused by the use of epoxide resin hardeners in refrigerators in abattoir.
B3829/C	Protein Cereal Baby Food	Larva of Larder Beetle present in food.	Packers informed. Stocks and storage premises examined.

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B3846/C	Boiled Ham	The results of analysis confirmed that the ham had undergone spoilage to some extent.	Remainder of stock surrendered for destruction.
B3842/C	Fruit Cake	Contaminated with mould of Aspergillus group.	Bakers interviewed and warning letter sent.
B3860/C	Milk	Bottle contaminated with patches of grit.	Dairy manager interviewed.
B3861/C	Large White Sliced Loaf	Infected with penicillium mould.	Premises had recently changed hands. Lack of evidence about time of sale.
B3876/C	Large White Loaf	Moth embedded in crust; its condition was consistent with it having been baked in the loaf.	Warning letter sent to bakehouse.
B3852	Tomato Ketchup	Slightly high mould count.	Further sample satisfactory.
B3899/C	Chocolate Covered Cake	Slightly affected by mould. Fats in cake beginning to go rancid.	Manufacturers interviewed and vendors interviewed and cautioned.
B3910/C	Lunch Meat Loaf	Meat putrid and discoloured. Can heavily rusted.	Investigation carried out with manufacturers. All suspicious cans withdrawn.
B3937/C	Sausage Roll	Extensively affected by mould.	Action under consideration.
B3964/C	Meat and Potato Pie	Harvestman had been cooked in the pie.	Warning letter sent and premises inspected.
B3948	Non Brewed Condiment	Contained only 3.2 per cent of acetic acid compared with the accepted standard of 4 per cent.	Bottlers informed. Further sample to be taken.
B4010/C	Vinegar	Vinegar fly present.	Stocks investigated. Manufacturers notified.
B4011/C	Vinegar (not from same source as B4010/C)	Vinegar fly present.	Stocks investigated. Manufacturers notified.
B4020/C	Milk	Film of mould growth present in the milk bottle.	Dairy notified and cautioned.
B4028/C	Baby Food	Contained three live Australian Spider Beetles and two pupa cases.	Packers notified. Thorough investigation carried out, concluded that infestation had probably taken place after despatch from packer.

Serial Number	Description	Nature of adulteration or irregularity	Remarks
B4049	Mincemeat	Dried fruit content low.	Further samples taken and found to be satisfactory.
B4050	Raising Powder	Residual carbon dioxide 1.7% as compared with maximum of 1.5% fixed by Food Standards Order.	Further sample to be taken.
B4060/C	Stuffed Pork Roll	Contained excess tin.	Canners notified, stocks withdrawn from retailers.
B4071/C	Milk Bottle	Contained a deposit of sandy matter and calcium salts – probably cement.	Dairy notified.
B4091	Dried Fruit Mixture	The proportions of the individual constituents differed from those expected from the order of the list of ingredients.	Further sample satisfactory.
B4107	Seidlitz Powders B.P.C.	The sample contained sodium potassium tartrate and sodium bicarbonate outside the B.P.C. limits.	Last of existing stock. No further action.
B4120	Pepper	Contained 80 ppm sulphur dioxide in contravention to the preservatives in Foods Regulations 1962.	Follow up sample satisfactory.

Pasteurised Liquid Eggs

All liquid egg for sale for human consumption, other than that broken on a food manufacturer's premises, must be pasteurised to destroy any harmful micro-organisms that may be present.

The Liquid Egg (Pasteurisation) Regulations 1963, specify the conditions necessary to effect pasteurisation and also prescribe a test – the alpha-amylase test – to be used to show that the treatment has been satisfactory. The test is very sensitive and stringent precautions must be followed when cleaning the sampling and testing equipment to ensure that it will not give rise to anomalous results.

During 1966, 58 liquid egg samples were taken and submitted to the alpha-amylase test. One sample failed the test, and the test on another was void. These results were suspected to be due to sampling in an incorrect container. The repeats of these samples and all other samples were satisfactory.

FERTILISERS AND FEEDING STUFFS ACT, 1926

Under the Fertilisers and Feeding Stuffs Act 1926, the sale of fertilisers and feeding stuffs must be accompanied by a statement giving certain particulars of composition. For example, with compound fertilisers, the amounts if any of nitrogen, potash, phosphoric acid soluble in water and phosphoric acid insoluble in water must be given; for compound feeding stuffs the amounts if any of oil, protein and fibre must be given.

The amounts of these constituents present in the articles must agree within slight limits of variation, with the declared particulars. Failure to do so is liable to result in a prosecution under the Act.

Samples are examined to see that they do comply with these and other provisions of the Act.

The four fertiliser samples examined during the year were all satisfactory. No feeding stuffs were submitted.

MISCELLANEOUS SAMPLES

Swimming Bath Waters

Various techniques are in use for the chlorination treatment of swimming bath waters but the one generally recognised as the most efficient way of maintaining the water in a satisfactory bacteriological condition is known as the breakpoint method of chlorination. This method is designed to ensure as far as possible that the chlorine in the water is present in the free state and not as chloramines (chlorine combined with organic matter). Thus a much higher concentration can be tolerated without undue irritation and unpleasant odour and the chlorine is readily available for immediate attack on any fresh impurities which are introduced into the water.

Samples are taken at the various swimming baths in the City to check that an efficient treatment is being maintained. During the year under review 221 samples were taken for this purpose.

Contract Samples

These are samples of various commodities used by Salford Corporation and are submitted by the Central Purchasing Committee to see that they conform to specification and to ensure that satisfactory products are obtained at competitive prices.

The 160 samples examined during 1966 consisted of synthetic detergents, soaps, polishes, scouring powders, sweeping compounds, metal polish, turpentine substitute, bleaching solution and various foodstuffs.

Pharmacy and Poisons Act Samples

No samples were examined during the year.

Other Miscellaneous Articles

Samples in this category included the following :–

Stuffed toy rabbit :	This had been washed and placed in a warm place overnight to dry. Next morning several 'toadstools' were found to be growing from the rabbit, the largest being some 2½ inches long and 1 inch in diameter. These were identified as members of the Coprinus species – a fairly common, non-toxic species.
Thinners :	Submitted by the Weights and Measures Inspector. Found to consist of hydrocarbons of the toluene type and therefore classed as 'petroleum' under the Petroleum (Consolidation) Act, 1928.
Arsenious oxide and zinc phosphide :	Taken to determine if storage had caused any deterioration and hence loss of efficiency as rodent poisons.
Pigeon and starling droppings :	Analysed for uric acid content.
Adhesive plaster remover :	Carbon tetrachloride determined to assess hazard when used continually in enclosed space.
Dusts from extraction units at the Cleansing Department :	These were analysed for plant nutrients with a view to their use as composts by the Parks Department.
Drinking water :	Numerous samples were analysed mainly as a result of complaints about the presence of insoluble deposits or aquatic insects or excessive chlorinous tastes.
Charred matter :	This was examined in connection with an alleged air pollution nuisance. It was found to be charred fragments of softwood.
Cabbage and potatoes :	These were examined for Vitamin C content in the raw state, after cooking, and several hours later after having been transported from the central kitchen.
	The cabbage lost some 25 per cent vitamin C on cooking and 50 per cent after cooking and transporting.
	Potatoes lost some 30 per cent on cooking but after mashing and transporting the total loss was 95 per cent.

AIR POLLUTION

The two main contaminants of urban air are smoke and sulphur dioxide. Since the Clean Air Act of 1956, efforts have been made to reduce pollution of the air by smoke, and to a lesser extent, by sulphur dioxide by introducing Smoke Control Areas.

Salford has for a number of years been participating in the National Survey of Air Pollution in collaboration with Warren Spring Laboratory of the Ministry of Technology. In this survey the smoke and sulphur dioxide concentrations are measured daily at various sites in the area.

The results for the six Salford sites are given in the following tables. These show that there has again been a considerable reduction in air pollution, the overall average for smoke being 43% lower and that for the sulphur dioxide 23% lower than in 1961.

TABLE 6

Smoke Pollution

Average daily readings for the different months of the year.

Results expressed as microgrammes per cubic metre of air.

Month 1966	SITE					
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place	Landseer Street
January	424	–	407	533	290	455
February	327	129	319	407	193	325
March	355	124	217	215	122	410
April	157	91	191	210	102	207
May	155	66	130	111	39	117
June	102	51	94	74	41	–
July	145	36	91	70	48	119
August	270	77	138	128	78	140
September	501	172	265	135	145	239
October	676	229	341	433	302	341
November	755	198	320	413	220	341
December	–	137	328	314	211	304
Daily average for the whole year	352	119	237	254	149	273
Average for 1965	319	171	278	270	200	283
1964	406	208	318	289	255	
1963	421	246	356	300	286	
1962	512	300	408	333	331	
1961	548	307	429	372	352	

Overall Average 1966 – 230
1965 – 254
1964 – 298
1963 – 320
1962 – 377
1961 – 402

TABLE 7

Sulphur Dioxide Pollution

Average daily readings for the different months of the year.

Results expressed as micrograms per cubic metre of air.

Month 1966	SITE					
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place	Landseer Street
January	327	–	474	440	388	427
February	303	200	311	350	321	369
March	274	156	272	239	194	367
April	279	177	298	246	218	335
May	165	185	238	299	157	202
June	199	165	206	210	176	–
July	120	106	125	142	138	215
August	297	134	185	169	179	95
September	414	228	291	113	244	93
October	473	199	350	320	310	114
November	549	144	337	301	232	133
December	–	106	308	321	314	460
Daily average for the whole year	309	164	283	263	239	255
Average for 1965	315	163	293	259	302	344
1964	361	170	319	275	311	
1963	385	189	358	303	344	
1962	439	193	367	300	356	
1961	472	158	294	326	388	

Overall Average 1966 – 252
1965 – 279
1964 – 296
1963 – 312
1962 – 331
1961 – 328

TABLE 8

Smoke/Sulphur Dioxide Ratios

Year	SITE					
	Regent Road	Cleveland House	Police Street	Murray Street	Encombe Place	Landseer Street
1961	1.16	1.94	1.46	1.14	0.91	–
1962	1.17	1.55	1.11	1.11	0.93	–
1963	1.10	1.30	1.00	0.99	0.84	–
1964	1.12	1.22	1.00	1.05	0.82	0.98
1965	1.01	1.05	0.95	1.04	0.66	0.82
1966	1.14	0.73	0.84	0.97	0.62	1.07

Carcinogenic Hydrocarbons

Smoke stains from one of the sites are measured for the presence of certain polynuclear hydrocarbons which possess carcinogenic properties. The results in the following table represent the total concentration of pyrene, coronene, 3.4 benzpyrene and 1.12 benzperylene expressed as microgrammes per cubic metre of air and also as parts per million of hydrocarbons in the smoke.

TABLE 9

Concentration of Carcinogenic Hydrocarbons

Month	Microgrammes of pyrene, coronene, 3.4 benzpyrene and 1.12 benzperylene per cubic metre of air	PPM Hydrocarbons in the Smoke
January	7.2	167
February	7.7	120
March	11.0	144
April	3.6	126
May	4.1	230
June	1.5	85
July	1.6	96
August	12.0	480
September	–	–
October	23	147
November	5.2	94
December	4.5	144

Radioactivity

Weekly measurements of the total beta radioactivity in smoke were continued during the year. This is done by continuously drawing air through a filter for a period of seven days and determining the activity of the particulate matter collected on the filter. Several days are allowed to elapse between sampling and measuring to allow any natural radioactivity to decay.

The results were very constant throughout the year and averaged 0.016 pico-curies per cubic metre of air. The maximum level recommended by the International Committee for Radiological Protection is 33 pico-curies per cubic metre.

DOMICILIARY MIDWIFERY SERVICE

Two important changes have been initiated during the year and another experiment (the attachment of midwives to the family doctors) has continued to progress with marked advantages to the Midwifery Service as a whole.

GENERAL PRACTITIONER (SHORT STAY) MATERNITY UNIT

This, an experimental scheme, and the second only to be started in this country, opened in September.

Previous discussions regarding the use of a four-bedded wing attached to the New Maternity Unit at Hope Hospital has been held and while several possible uses for this wing were forthcoming, it was decided to try first an experiment which had shown some degree of success in Cardiff.

The wing, a unit with four single bedrooms and with independent "utility" rooms, is adjacent to the ground floor of the New Maternity Unit and the proposal viz:– to admit in labour, deliver and immediately transfer home (i.e. within approximately 6 hours) a selected group of mothers has at least three major advantages :–

a) the immediate and simple transfer through to the hospital should any complication arise,

b) the family doctor and domiciliary midwife remaining responsible for the mother giving continuity of care and being well-known to her,

c) the short period only which the mother is away from her other children.

Basically the domiciliary midwife takes the mother to the unit and remains with her during her labour – the husband or relative is encouraged to stay throughout and the family doctor visits and/or stays in the same way as for a home confinement. The mother is transported to and from the Unit by the Ambulance staff, who have been co-operated well, and delay in transport has been minimal.

The catchment area for the unit has been determined by the distance from the unit of the Doctor's and Midwife's normal field of operation – for they cannot be divorced from their normal responsibilities – thus it is also necessary for a midwife working in the unit to have her own independent transport (and Salford midwives are not yet provided with a car or loan facilities).

Initially twenty bookings per month have been allocated each to Salford and Lancashire County Council and the number will be re-adjusted as the potentialities of the service are known. Twenty-eight mothers were delivered in the unit up to December 31st : twenty from Salford and eight from Lancashire. There are, of course, some disadvantages and problems in the scheme but the unit is proving popular with most mothers, doctors and midwives and is becoming more widely known and used.

The Salford allocation of beds is fully booked for the first half of 1967 and a survey is to commence soon to help to asses the value of this experiment.

Summary of Salford Mothers Booked September – December 1966

Number actually booked	42
Delivered in unit	20
Delivered at home (labour too advanced for transfer)	5
Booking transferred to hospital	11
Moved from district	1
Admitted to unit but transferred before delivery	1
after delivery	2
Not yet delivered	4

A criterion for the selection of mothers (which was allowed for considerable elasticity) was proposed viz:–

1) Healthy primigravida or multigravida whose home conditions are good but who for emotional reasons require the "safety" of hospital precincts,

2) Those patients whose home conditions are borderline, e.g. overcrowded for delivery but suitable for early post-natal period,

3) Pregnant women with good homes who have had some previous minor obstetrical complication not likely to recur.

It was agreed by all staff concerned i.e. Consultant, Obstetrician, Family Doctor and Local Authority Representatives that the unit should not be used for abnormal obstetrics.

Midwifery Training School

In order to increase the number of places available for the training of midwives, the Central Midwives Board has been increasing the number of Part II schools attached to hospitals throughout the country.

In Salford, our own Part II school, giving six months experience in domiciliary midwifery has continued, but in addition pupils are taken for 3 months from Hope Hospital Part II school. This will ultimately increase the number of midwives trained in Salford by 33% and should prove a help to the general maintenance of practising midwives throughout the country.

It is envisaged, in the near future, to use a wider area for the training of pupils, necessitated by several factors:–

1) The attachment of midwives to family doctors has meant that the

midwife's (and pupil's) area of work is larger and more sporadic.

2) The tendency for fewer babies to be born at home and re-development in the area has given an insufficient number of cases in the already established training area,

3) The need for more midwives to share the responsibility for the training of the increased number of students.

JUTLAND HOUSE

Continues – an old, building in an undesirable area for the residence of nurses – and with a high maintenance cost. It would repay the City of Salford to reconsider the building of a modern nurses home with teaching unit at an earlier date than that at present proposed.

ATTACHMENT OF MIDWIVES TO FAMILY DOCTORS

Midwives are now attached to ten Family Doctors, and in each case the midwife attends the ante-natal session of the doctor's surgery. She undertakes the responsibility with the doctor for the care of each mother and when possible is with the mother in labour.

If the midwife attached also has her own car she is responsible for the preparation of the home and the early post-natal period which gives continuity of advice throughout.

The mother attends one place only for her ante-natal care and meets her doctor and midwife – the doctor holds his ante-natal session at a separate time from other surgery periods and more time is given to the individual mother. Correspondingly, the number of attendances at the local authority clinics has been reduced, allowing more time to be given to the individual mother there.

The appointment system, established in 1962, has allowed a complete re-organisation in the running of the clinics, and mothers now lose little time in waiting and the clinics are less crowded and more peaceful. The mother is able to adjust her appointment to fit in with her other responsibilities, e.g. collecting other small children from school.

STATUTORY SUPERVISION OF MIDWIVES (Midwives Act, 1951)

Notification of Intention to Practise

In accordance with the provisions of the above Act, the number of midwives who notified their intention to practise was as follows:–

(a) Institutional	52
(b) Domiciliary	32
(c) Private Practice	1
Total	85

Compulsory Post-Graduate Courses

In accordance with the rules of the Central Midwives Board, midwives have continued to attend, at least once in every five years, courses arranged for post-graduate instruction.

Attendance by Salford Midwives, 1966

(a) Institutional	3
(b) Domiciliary	5
(c) Supervisory	1

These courses are held at various centres throughout the country and give excellent opportunity for discussing old and new ideas, the interchange of local innovations, and for meeting people in all fields of midwifery.

Miscellaneous Notifications

(as required by the rules of the Central Midwives Board)

Notification	Domiciliary	Private Practice	Total
Stillbirths	5	–	5
Death of Mother/Baby	2 (baby)	–	2
Infection	16	–	16
Medical Aid	953	–	953

STAFF POSITION (December 31st)

	Establishment	1966	1965	1964
Supervisor and Tutor	1	1	1	1
Assistant Supervisor	1	1	1	1
Midwives – Full Time	27	20	21	22
Midwives – Part Time	–	3	3	4
Breast Feeding Sisters	2	2	2	2
Premature Baby Sisters	3	3	3	3

STATISTICS

(1) Clinics

(a) Attendances :– Statistics relating to ante-natal clinic attendances will be found under "Care of Mothers and Young Children".

(b) Bookings :–	Number of domiciliary bookings	1,268	(1,427)
	Number of cancellations, transfers to hospital, removals etc.	359	(536)

(2) Home Visiting

(a) Follow-up of clinic defaulters (b) Routine home ante-natal visits	8,882	(10,742)
(c) Investigation of home conditions		
Actual homes	348	(386)
Number of visits	2,122	(1,660)

COMPARATIVE STATISTICS – HOME INVESTIGATIONS

Year	1966	1965	1964	1963	1962
Totals	348	386	340	478	264

BIRTHS

(1) Statistics

Doctor booked and present at delivery	44	(71)
Doctor booked, not present at delivery	842	(1,031)
Doctor not booked, present at delivery	0	(2)
Doctor not booked, not present at delivery	4	(8)
Delivered in G.P. Unit Doctor Present	13	
Doctor Not Present	7	
Total Births	910	(1,112)

Domiciliary births formed 52.05% of total Salford Births

COMPARATIVE STATISTICS

Year	Live Births	Stillbirths	Total
1962	1,341	8	1,349
1963	1,222	12	1,234
1964	1,207	2	1,209
1965	1,108	4	1,112
1966	885 (at home) 20 (in G.P. Unit)	5	910

Number of nursing visits following delivery	15,543	(18,385)
Number of nursing visits for hospital discharge	8,443	(6,714)
Total	23,986	(25,099)
Number of discharges from hospital under 10 days	984	(953)
Number over 10 days requiring midwife (Excluding premature babies)	62	

(2) Analgesia

	Number of Mothers
Nitrous Oxide	–
Trilene	693
Pethidine	600
Total Inhalation Analgesia	693 i.e. 76% of all births

(3) Stillbirths

(domiciliary bookings)

Comparative Statistics	Number of Stillbirths (born at home)	Rate per 1,000 Registered births
1962	8	6.0
1963	12	9.9
1964	2	1.25
1965	4	3.5
1966	5	4.05

SUMMARY OF CASES

Born at Home

Classification		Presentation	Gestation	Weight	Remarks
Ante-Partum Anoxia	1	Vertex	36 weeks	5.14	Macerated Foetus– Anencephalic.Mother Rh– No anti-bodies
Intra–Partum Anoxia	1	Vertex,	41 weeks	7.0	Fresh Foetus – Heart failed during 2nd stage. No abnormality
	2	Vertex	42 weeks	8.12	Fresh Foetus – Heart failed during 2nd stage. Mother Rh – No anti-bodies
	3	B.B.A.	? 36 weeks	5.8	Para XI. No ante-natal care; P.M. Hypoplastic colon
	4	Vertex	34 weeks	6.8	Gross abnormalities Para VII

Booked for Home and delivered in Hospital		Reason for Transfer	Number
Transferred before labour	2	Ante-Partum Haemorrhage	1
		Pre-eclamatic Toxaemia	1
Transferred during labour	3	Ante-Partum Haemorrhage	2
		Premature labour	1

(4) Neo-natal Mortality (Domiciliary bookings)

Deaths from Birth up to 28 days		Cause of Death	Age at Death
Born and died at home	2	(1) Gross Abnormalities	5 mins
		(2) Prematurity and Foetal abnormalities (2 lbs)	15 mins
Born at home and transferred to hospital	5	(1) Gross Abnormalities	3 days
		(2) Pneumonia	6 days
		(3) Asphyxia and Prematurity	2 days
		(4) Congenital Heart Deformity	2 days
		(5) Congenital Heart Deformity	1 day
Born in G.P. Unit and transferred to Hospital	2	(1) Encephalocele	5 mins
		(2) Congenital Heart Failure and Asphyxia Neonatorum	55 mins

		Reason for Transfer	Number
Mothers booked for home confinement and transferred to hospital before delivery	15	Polyhydramnios	1
		Rh Negative with anti-bodies	2
		Postmaturity	1
		Ante-partum Haemorrhage	4
		Premature Labour	4
		Pre-eclamptic Toxaemia	1
		Delay in labour	1
		Prolapsed cord	1

(5) Puerperium

Infection	Hospital	Domiciliary	Total
Puerperal Pyrexia	21	2	23
Ophthalmia Neonatorum	–	–	–
Pemphigus Neonatorum	–	–	–

Causes of Pyrexia were as follows :–

	Hospital	Domiciliary	Total
Uterine Infection	8	–	8
Urinary Infection	3	1	4
Chest Infection	1	–	1
Breast Infection	2	–	2
Wound Abscess	2	–	2
Gastro-enteritis	1	–	1
Undiagnosed	4	1	5

BREAST FEEDING AND PREMATURE BABY SERVICES

(6) Premature and Immature Babies

Number of babies visited — born at home	47
— born in hospital	82
Total number of visits made	2,104

Breast Feeding Service

Number of babies visited — born at home	84
— born in hospital	55
Total number of visits made	1,522

PREMATURE BIRTHS

Number of premature births (as adjusted by any notifications transferred in or out of the area

Weight at birth	Premature live births												Premature stillbirths	
		Born in hospital			Born at home or in a nursing home									
					Nursed, entirely at home or in a nursing home				Transferred to hospital on or before 28th day					
	Total births	Died			Total births	Died			Total births	Died			Born	
		within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days		within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days		within 24 hours of birth	in 1 and under 7 days	in 7 and under 28 days	in hospital	at home or in a nursing home
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
1. 2lb 3oz or less	7	7	–	–	1	1	–	–	1	–	–	–	6	–
2. Over 2lb 3oz up to and including 3lb 4oz	16	5	–	–	–	–	–	–	–	–	–	–	9	–
3. Over 3lb 4oz up to and including 4lb 6oz	41	1	3	–	1	1	–	–	3	–	–	–	9	–
4. Over 4lb 6oz up to and including 4lb 15oz	59	4	2	2	4	–	–	–	4	–	–	–	3	–
5. Over 4lb 15oz up to and including 5lb 8oz	82	2	2	1	28	–	–	–	6	1	1	–	1	1
6. Total	205	19	7	3	34	2	–	–	14	1	1	–	28	1

1 = 1,000g, or less, 2 = 1,001 – 1,500g, 3 = 1,501 – 2,000g, 4 = 2,001 – 2,250g, 5 = 2,251 – 2,500g

SALFORD PART II MIDWIFERY TRAINING SCHOOL

Pupil Midwives who completed training during 1966

Completely on the District	18
3 months hospital and 3 months district	11

STUDY OF STILLBIRTHS AND INFANT MORTALITY IN SALFORD, 1965

As has been mentioned in recent annual reports, a study was started in 1965 to investigate all still births and infant deaths in the City. The rates continue to be much higher than those of the country as a whole and show little sign of improvement. Various large scale studies have recently shown that deaths of babies at or around birth are most likely to happen when the mothers fall into certain age and parity groups, come from certain social backgrounds, seek care late in pregnancy and have a history of losing a previous child. The most important causes of death of the babies in question fall into the broad categories of prematurity, asphyxia and congenital abnormality.

The Salford investigation was planned not to look at these aspects, but to go in greater detail into the social factors which are involved. To do this a health visitor who was employed solely on this work collected the available information from records and then interviewed as many of the mothers as she could find. This turned out to be 85 per cent of the total. The interviews took place in the mothers' homes and usually took 1½ – 2 hours, so that there was adequate time to cover all aspects of the pregnancy and the life of the child.

The analysis of the results falls into two groups – those related to perinatal deaths (stillbirths and deaths in the first week of life), and those related to deaths later in the first year of life.

PERINATAL DEATHS

Two well-recognised factors seem to be particularly important in Salford – prematurity and a late start to ante-natal care. Only 27 per cent of the mothers attended a clinic before the end of the 4th month of pregnancy compared with 38 per cent in a control group of Salford mothers and 45 per cent in a recent national study. (The control group were all the Salford mothers who had babies born in October, 1965 and surviving the perinatal period).

Late ante-natal care was found to be related to a poor attitude on the part of the mother towards such care and the presence of problems in the family. Hardly any of the mothers realised that ante-natal care was intended to benefit the child as well as the mother. The problems present were such things as marital disharmony, a husband with a poor work record, uncertain or inadequate income, poor housing conditions, and chronic physical or mental illness.

Two special groups, where ante-natal care was poor in its early months, were the unmarried mothers and those who were married during the course of the pregnancy.

Many of the mothers found it impossible to discuss problems with the staff of the ante-natal clinics who were felt to be too busy to bother. As a

result, some serious conditions developed at home which were not treated as early as they might have been. This particularly happened with young, inexperienced mothers booked for hospital confinement. There seemed to be an idea that they could not consult their family doctor in these circumstances. Some mothers did not realise the seriousness of their symptoms and others did not comprehend or follow the advice given at clinics.

There would seem to be a need for some kind of plan for her pregnancy to be discussed with the mother with a view to seeing that she obtained adequate early care. In view of the fact that 75 per cent of the mothers consulted their family doctor before the end of the 4th month of pregnancy (often in the 1st. or 2nd.) this might be the best time for this to be done. It would improve the already close contacts between the family doctors, the domiciliary midwives and the hospital ante-natal clinics.

It is sometimes suggested that mothers find it difficult to get help from relatives or friends in looking after their older children while they are attending the clinic, or in other ways later in pregnancy, but there was no evidence of this in the survey. The same proportion as in the control group maintained close contact with their families.

When the health visitor went to the mothers for the purpose of this enquiry, she found that they welcomed an opportunity to talk over the events at leisure with someone who was able to give them some help and advice with their problems. The extent of these can be gauged by the fact that only a quarter of them were satisfied with and understood the explanations they had been given of the child's death. About a third expressed dissatisfaction and felt unable to ask questions of their doctor or the clinic. This is a serious state of affairs when it is realised that a history of the loss of a child leads to a greater risk of another death in a future pregnancy. The possibility of a recurrence worried many of the mothers but they had not been given much advice about this.

This points to the desirability of mothers who lose babies at this age being visited by health visitors in the same way as the more fortunate mothers of living babies. Their problems may be different, but their needs are no less pressing.

DEATHS LATER IN THE FIRST YEAR

More than half of the deaths in the first year of life occur in the first week. Apart from the result of congenital abnormalities, most of the later deaths are due to infection of one kind or another. The most numerous are those ascribed to "pneumonia" or some similar term. Most of these deaths are sudden and unexpected and the cause of death is determined after inquiry by the Coroner. The typical story is that the baby is aged between 2 and 6 months, has been well or at the most had a slight cold, has been put to bed as usual one night and found to be dead next morning. This type of death has been well known for years and has been the subject of much debate and enquiry without any definite conclusions. 19 of the 35 later deaths in Salford in 1965 fell into this category.

Our study was designed to look at the social background of these deaths, rather than the medical cause or causes which would require greater numbers or more elaborate investigations. Only 16 of the 19 mothers were interviewed and the results must be treated with some reserve. 2 of the other 3 families left Salford immediately after the death and the other refused to be visited.

The mothers seen were found to have delayed before seeking care during pregnancy; to have an exceptionally poor attitude to ante-natal care (these two obviously go together in many cases); to have had a poor diet and lived in poor housing conditions. Three-quarters of them were judged to have serious problems and these could be divided into two broad groups – families of Salford origin who were cut off from other members of their families for some reason, and families characterised by a shifting unsettled way of life who had no strong roots in any area.

Almost all the families who lost a child in this way seemed to have a variety of problems, all of which would affect the upbringing of the child. All but one of the babies had been ill to some extent in the two weeks before death – half of them had been seen by a doctor. In a number of cases there had been arguments in the family as to whether the doctor should be called particularly if the illness was judged serious at night or the weekend. The study emphasised that for most families, the decision to call a doctor is not an easy one to make and is affected by factors such as the absence of the father or the memory of previous contacts with the health services – other than the apparent seriousness of the illness.

The study seemed to indicate that particular attention should be given to minor respiratory diseases when they occur in babies aged under a year in families of the kind described, and that doctors and other health workers should not class them as minor without full consideration of the history and signs. Very few indeed of the deaths occurred in what could be described as an average Salford family.

It is, however, notoriously difficult to study events after the unexpected death of an apparently healthy baby, and study of this type of death is continuing.

CARE OF MOTHERS AND YOUNG CHILDREN

STATISTICS

Births

During the year, 4,131 live birth notifications were received, 240 of which referred to births outside the City to Salford residents. There were also 87 stillbirth notifications and 7 of these stillbirths occurred outside the City to Salford residents.

The adjusted births for Salford were 2,802 live births and 61 stillbirths; these figures related to the Registrar General's estimated mid-year population for Salford of 145,880, give a live birth rate of 19.2 per 1,000 population and a stillbirth rate of 21.3 per 1,000 registered births. The figures for 1965 were 20.6 and 21.79 respectively.

Of the total notified births 78.7% were hospital and of the births occurring to Salford mothers 68.6% were hospital deliveries.

In 1965, 64.5% of the births took place in hospital. 26 of the live births took place in the General Practitioner Unit at Hope Hospital which was opened in October 1966. These births are recorded as institutional deliveries for statistical purposes, but the mothers are attended by their own family doctors and by local authority midwives during their confinement in this Unit. It is expected that the proportion of institutional deliveries will rise in the coming year now that the G.P. Unit is fully operational.

Illegitimate Births

During 1966 there were 333 illegitimate live births and 7 illegitimate stillbirths registered in Salford. The percentage of illegitimate live births is 12.11 the highest figure ever recorded in this City.

Infant Deaths

The total loss of infant life during 1966 was 61 stillbirths and 88 deaths during the first year of life.

The stillbirth rate is 21.3 per 1,000 total registered births and this is the lowest figure recorded in this City.

There were 51 deaths during the first week of life (32 of which occurred on the first day of life) and the early neonatal mortality rate is 18.2 per 1,000 live births. This figure has varied over the years, but there has been a gradual improvement during the past 4 years. The early neo-natal mortality rate was 13.18 in 1959, 15.05 in 1960, 14.58 in 1961, 15.63 in 1962, 18.07 in 1963, 17.03 in 1964 and 15.06 in 1965.

The perinatal mortality rate i.e. stillbirths and deaths during the first week of life, is 39.12 per 1,000 registered births. This figure has remained fairly constant over the past eight years.

There were 59 infant deaths during the first month of life and the neonatal mortality rate is 21 per 1,000 live births. This is the highest figure recorded since 1958. In all there were 88 deaths in infants under 1 year of age, and the infant mortality rate is 31.4 per 1,000 live births. This is the highest figure since 1953.

The following table shows the age distribution of infant deaths together with the death rates.

Stillbirths	61	112 Perinatal deaths			
Death under 24 hours	32	Perinatal mortality rate 39.12	51 early Neonatal deaths Death rate 18.2	59 neonatal deaths Death rate 21.05	88 infant deaths Death rate 31.4
,, 1 to 6 days	19				
,, 7 to 27 days	8				
,, 1 to 11 months	29				

The principal causes of death in infants under 1 week of age are prematurity (19) respiratory disease (15) and congenital malformation (10). In infants between 1 week and 1 month of age the principal cause of death is congenital malformation (5) and in infants between 1 month and 1 year of age the principal cause of death is respiratory disease (22).

It is interesting to speculate on the stillbirth rate, the perinatal mortality rate and the neonatal mortality rate. In the first case we have reported the lowest figure ever recorded, in the latter case we have recorded the highest figure since 1958 and the perinatal mortality rate hovers around 40.0 per 1,000 registered births. It may well be that infants who formerly did not survive the hazards of birth are now being born alive, only to succumb in the first days or weeks of life. The importance of congenital malformation as a cause of death in the 2nd, 3rd and 4th weeks of life must not be overlooked and it is suggested that the intensive nursing care given to children with malformation helps them to survive the first few days of life, but cannot prolong life indefinitely.

When considering respiratory causes of death, a distinction must be made between the respiratory causes of death in infants under 1 week of age, and respiratory causes of death in older infants. In the former case the deaths are almost entirely due to respiratory distress syndrome, i.e. difficulty in establishing respiration, whereas in older infants the deaths are due to respiratory infection. The remedy is all too obvious; there must be a greater awareness of the dangers of respiratory infections in young children; parents must be more willing to seek medical advice and this advice should be readily and willingly available to all who seek it.

Deaths 1 to 4 years

There were 13 deaths in the age group 1 to 4 years during 1966, in 1965 there were 9 deaths, and in 1964 11 deaths in this age group.

The table below shows the age distribution and the causes of death.

Cause of death	1 year	2 years	3 years	4 years	Total
Respiratory disease	1	1	–	2	4
Accidental death	–	2	1	1	4
Malignant disease	–	–	–	2	2
Congenital malformation	–	–	2	–	2
Others	1	–	–	–	1
	2	3	3	5	13

As in previous years the main hazards for the pre-school child are accidents and respiratory diseases. Accidental death in early childhood is only a fragment of the total toll of accidental deaths and this problem must be tackled on a nationwide basis.

The children in this City must have play space to which they can gain access without having to cross busy city streets and there must be a growing awareness of the dangers that lurk in every home. Faulty electrical wiring is thought to have been the cause of a house fire which cost the lives of three children. We must redouble our efforts in the field of accident prevention and we must also strive to ensure that every parent appreciates the danger of leaving young children alone in the house, even for a few minutes "just while I run round to the corner shop".

Respiratory deaths in the pre-school child are part of the overall picture of respiratory disease which is still the scourge of industrial areas in the North of England. Any improvements in atmospheric pollution, housing, overcrowding, nutrition etc. will be accompanied by an improvement in morbidity and mortality from respiratory diseases, but we must guard against the dangers of providing housing accommodation which is so expensive that the nutrition and the welfare of the younger members of the family deteriorates.

Maternal Deaths

During the year no Salford mother died from any cause due to, or associated with pregnancy, childbirth or abortion.

One Salford mother died one month after delivery from pre-existing malignant disease, but it is believed that the course of this disease was not adversely affected by the mother's pregnancy.

REGISTER OF CONGENITAL MALFORMATIONS

At the present time information for this register is obtained from the birth notification cards which have been printed to include a reference to the presence of congenital malformation and also from hospital discharge letters which are written by the medical staff. The birth notification cards provide information about congenital malformations immediately apparent at birth e.g. meningo myelocele, exomphalos, anencephaly etc. and the hospital discharge letters provide information about malformations which are diagnosed on medical examination e.g. congenital dislocation of the hip, congenital heart disease etc.

Unfortunately the scheme of notification of congenital malformations is limited to those malformations identified at birth or shortly afterwards and there is no procedure for notifying to the Registrar General congenital malformations which are diagnosed later in life. This can only mean that any statistics based on this register must be carefully interpreted and it must not be assumed that they give a complete picture of the incidence of congenital malformations.

During the year a total of 89 children suffering from congenital malformations were notified to the local authority and the children were divided into categories as below :–

Central Nervous System	23	Of these children 7 suffered from 2 or more malformations.
Eye and Ear Defects	3	
Alimentary System	5	Of these one child suffered from a second malformation.
Heart and Great Vessels	5	Of these one child suffered from a second malformation.
Respiratory System	Nil	
Urogenital system	8	One child in this category suffered from a second malformation.
Limbs	24	Of these 4 children suffered from multiple abnormalities.
Other Skeletal Abnormalities	2	One of whom suffered from multiple defects.
Other Systems	10	
Other Malformations	9	This category includes five children who were born with multiple malformations not otherwise specified.

(Children with multiple abnormalities are included in the category of the major defect whenever this is specified).

The number of stillborn infants with congenital malformations was 9 and during the year 17 of the notified infants died. This represents an infant loss of 29 per 100 live and stillbirths. Forty-two surviving children were put on the Handicapped Register and 18 were put on the At Risk Register. Special follow up was not thought necessary for three infants with trivial malformations.

In spite of all criticism, it must be admitted that the Register of Congenital Malformations is an important source of information for compiling a register of handicapped children, and one of the most important features is the early age at which the local health authority is informed of the handicap.

AT RISK REGISTER

The total number of children on the At Risk Register on December 31st, 1966 was 688. The number of new notifications during the year was 340. This is a reduction of 124 compared with 1965 when there were 464 new notifications and it is due to the higher degree of selection e.g. infants delivered by simple forceps deliveries without complications or infants with birthweights over 4½ lbs are not included in the At Risk category.

During the year 5 children on the At Risk Register died (2 children died from virus pneumonia, one child died of bronchopneumonia, one child was found dead in his cot and one child died of post operative complications following a major operation), and 6 children were transferred to the Handicapped Register. In 4 cases the handicap suffered by the child was related to the At Risk factors which had been identified at birth.

Information about the children on the register comes to the Health Department in the form of hospital discharge letters, and reports from members of the Health Visiting Staff. In order however, to reduce the time spent in writing reports, the infant's Child Welfare notes are studied and only if an infant does not attend a clinic is the Health Visitor asked to make a special report. Even so a considerable number of reports are requested each month.

During the year a new system of reporting hospital discharges from the Maternity Unit at Hope Hospital was introduced. The proforma now includes specific reference to At Risk categories and these are coded for easy reference. Unfortunately the amount of information is not so detailed as in the past, and it is expected that the number on the At Risk register will rise sharply in the forthcoming year.

There is no doubt that maintaining an At Risk register is time consuming and not very rewarding in terms of identifying handicapped children and this aspect of the work is receiving some attention from research workers.

HANDICAPPED REGISTER

The number of children on the Handicapped Register at the year-end was 365. During the year, 142 new notifications were received and a total of 479 handicapped children were followed up and supervised by public health nursing and medical staff.

The following table shows the number of children notified during the year and the number of children on the register at December 31st divided into categories :–

Category	New notifications during 1966	Total number on the register at December 31st
Blind	–	1
Partially sighted	4	8
Other eye defects	1	2
Deaf	1	1
Partial hearing	1	3
Delicate Respiratory	3	11
,, Circulatory	17	42
,, Gastro intestinal	8	23
,, Genito urinary	7	18
,, Other	19	39
Epileptic	4	8
Convulsions	8	21
Mental retardation	23	54
Cerebral palsy	3	9
Organic diseases of the Central Nervous System	15	40
Orthopaedic Defects	26	72
Cleft palate	1	11
Speech defects	–	–
Socially handicapped	1	2
	142	365

(Note that when a child suffers from multiple handicaps the child is included in the category of the major defect).

The main source of new referrals is the register of Congenital Malformations but hospital discharge letters and information from the Health Visiting staff remain of major importance in providing information about newly diagnosed handicaps and about the subsequent progress of the children. The children's special needs are also identified and made known by these means.

During the year 37 children were notified to the Principal School Medical Officer for medical examination prior to admission to school: 3 children were notified to the Mental Health Section and 15 children were notified to both the School Health and the Mental Health Service. In the latter case the children are so severely handicapped both mentally and physically that their suitability for education in school cannot easily be decided and these children are on the waiting list for admission to Broughton Training Centre and Special Care Unit for a period of training and assessment.

At the year-end there were 30 children on the register suffering from multiple handicaps and as in previous years the largest group within this category includes children who suffer from mental retardation combined with a physical handicap such as congenital heart disease or an organic lesion of the nervous system.

During the year the names of 113 children were removed from the register: 7 children were considered to be cured, 32 children removed to addresses outside Salford, 14 children died (eight of these children died within 1 year

of notification), and 60 children reached the age of five years. Arrangements for the education of these children are as below :–

Admission to ordinary Day School	28
Day School for Physically Handicapped pupils	7
Day School for Delicate children	4
Partially Sighted class	2
Residential School for the Deaf	2
Parkfield Unit	4
Wilmur Avenue Training Centre and Special Care Unit	9
Refused to accept a place in a Training Centre	1
Permanent hospital care	1
No information available	2

In addition to these placements in school or training centre, 26 children under 5 years of age attended either a special school or a training centre as below.

Training Centre or Special Care Unit	15
Greengate Special Nursery School	5
Day School for Physically Handicapped pupils	4
Residential School for Physically Handicapped pupils	1
Permanent hospital care	1

In this field we encounter great difficulties as the provision of training and educational facilities for the under-5-year olds is insufficient both locally and on a national scale.

It is true that Salford is unique in having a Special Nursery School but the use of this school is limited to children living in the area of Greengate as there are no transport facilities available. The school, however, is always full and there is a waiting list of 24 names. The provision of training facilities for mentally handicapped children will be improved in the near future when the Margaret Whitehead School and Special Care Unit in Seedley is opened. In the meantime however, there is a long waiting list for this type of training and care (with emphasis on assessment). At the time of writing there are 12 children between 3 and 4 years of age and 8 children between 2 and 3 years of age, on the waiting list for admission to Broughton Training Centre, many of whom are in urgent need.

In addition to special schools and training centres there is a need for a day centre for handicapped children where these children can meet other children and join in creative play activities e.g. sand and water play, painting, cutting out, pasting, glueing etc. At such play centres there should be facilities for physiotherapy and speech therapy and, most important of all, facilities for assessing these children and their individual needs. Not only would such centres provide play and assessment facilities but they would fulfil an important social function, for many handicapped children are isolated within their own homes and their parents too often feel alone and excluded from society.

ANTE-NATAL CLINICS

The number of expectant mothers attending local authority ante-natal clinics continues to fall. The total number of attendances during 1966 was 7,380 compared with 8,370 during 1965, and the number of new attenders during the year was 1,088 compared with 1,227 in the preceeding year.

This fall in attendances is due to two reasons

(a) A fall in the total number of births in the City;

(b) A further increase in the number of general practitioners providing ante-natal services for their own patients on their own premises.

The attendances at the ante-natal clinics showed a steady decline throughout the year, and in September, 1966 a decision to reduce the medical staffing of the clinics was taken. The number of ante-natal clinic sessions remained at nine per week throughout the year, but a doctor attended Summerville, Trinity, Kersal and Langworthy (Thursday session) once per month from Monday, 31st October instead of fortnightly as in the first ten months of the year. Medical staff continued to attend Langworthy (Monday session), Ordsall Clinic and both sessions at Murray Street Clinic at fortnightly intervals.

A reduction in the numbers of ante-natal sessions held each week was under consideration at the end of the year.

The table below shows the work done at the ante-natal clinics during 1966 together with comparable figures for 1965.

ANTE-NATAL CLINICS – SUMMARY FOR 1966
(1965 statistics in brackets for comparison)

Clinics	No. of sessions weekly	Total individuals attending	Total attendances	New attendances	Consultations by	
					L.A.M.O.	G.P.
Trinity	1 (1)	114 (122)	578 (670)	87 (88)	140 (140)	– (23)
Kersal	1 (1)	141 (156)	794 (966)	120 (117)	115 (31)	67 (173)
Langworthy	2 (2)	331 (414)	1,752 (2,242)	264 (325)	102 (254)	258 (228)
Murray St.	2 (2)	407 (453)	2,040 (1,998)	322 (361)	92 (249)	389 (296)
Ordsall	2 (2)	245 (290)	1,400 (1,656)	197 (229)	256 (300)	– –
Summerville	1 (2)	127 (145)	816 (838)	98 (107)	124 (26)	15 (156)
TOTAL						
1966:	9	1,365	7,380	1,088	829	729
1965:	(9)	(1,580)	(8,370)	(1,227)	(1,000)	(876)

It should be noted that the column headed "consultations by G.P." refers to the work done by general practitioners employed on a sessional basis and does not include ante-natal patients attending their own family doctors for ante-natal care at the doctors' own premises.

Ante-natal Blood Tests

The numbers of blood specimens taken by medical officers attending the ante-natal clinics are as follows :–

For Wasserman P.P.R. and R.P.C.F. testing 814: of which 3 were positive.

For Haemoglobin testing 1,570.

For Rhesus screening testing 724: of which 92 were reported to be Rhesus negative. These mothers were invited to attend the Rhesus clinic, for further blood specimens to be taken and examined at the Blood Transfusion Centre.

A total of 186 mothers attended the Rhesus clinic and of this number 66 were found to be Rhesus positive and 120 were confirmed as having Rhesus negative blood. Sixty-two mothers attended for further anti body tests at the thirty second week in pregnancy. The total number of attendances at the Rhesus clinic was 248.

During the year 6 mothers were reported to have anti bodies and all were referred to the family doctor so that arrangements could be made for hospital confinements. In each case the outcome of the pregnancy was a normal healthy infant.

CHILD WELFARE CLINICS

Statistics for this year show that the total number of new attenders has decreased, but this decline has not effected all clinics equally, and in fact Cleveland, Regent Road and Trinity Centre have attracted more new attenders than in 1965. The total numbers of attendances at the clinics also show downward trends except at Cleveland, Regent Road and Trinity Centre. The table on the next page shows the attendances at the clinics, the number of individuals attending and the number of medical consultations, etc. during the year.

CHILD WELFARE CLINIC SESSIONS – 1966
(Statistics for 1965 in brackets)

Clinic	No. of Weekly Sessions	Total No. of Clinic Sessions	Attendances	Individuals	New Cases	Consultations	Referrals
Cleveland	2	98	2,213 (2,042)	374 (391)	159 (150)	290 (280)	19 (22)
Kersal	2	100	2,304 (2,627)	419 (448)	163 (183)	490 (403)	56 (26)
Langworthy	4	198	7,603 (8,303)	1,389 (1,616)	686 (756)	1,364 (1,578)	102 (118)
Murray Street	3	145	4,724 (5,593)	1,153 (1,333)	622 (733)	906 (944)	68 (175)
Ordsall	2	100	2,120 (2,385)	439 (496)	184 (237)	416 (384)	38 (49)
Police Street	3	149	1,938 (3,139)	460 (611)	190 (279)	214 (555)	25 (21)
Regent Road	3	150	3,001 (2,924)	741 (639)	358 (324)	600 (411)	47 (40)
Summerville	2	100	2,471 (2,674)	350 (380)	141 (145)	321 (289)	32 (31)
Trinity	2	96	1,834 (1,561)	398 (370)	185 (169)	397 (338)	25 (50)
Premature Baby	½	25	79 (67)	7* (22)	18 (15)	79 (67)	7 (3)
* Plus 35 who have also attended other Salford C.W. Clinics							
TOTALS	23½	1,161	28,287 (31,315)	5,730 (6,306)	2,706 (2,991)	5,077 (5,249)	419 (535)
Removed out in 1966				314 (281)			
Clinic attenders died in 1966				4 (5)			
Attended and reached 5 years in 1966				145 (111)			
GRAND TOTALS							
1966		1,161	28,287	6,193	2,706	5,077	419
1965			31,315	6,703	2,991	5,249	535

The fall in attendances at the clinics has been met by a reduction in the staff at the clinics, but each clinic still maintains a minimum of two child health or welfare sessions per week.

The average number of attendances at the clinics per child on the register (0 – 5 years of age) was 4.6 for the year and this can be analysed to show that infants under 1 year of age made an average of 6.5 attendances and children between 1 and 2 years of age 5.6 attendances, while children between 2 and 5 years made 2.3 attendances. These figures relate to those children who attended clinic sessions during the year and not to the estimated total child population of the City.

It is estimated that 12,629 children under 5 years of age were living in the City at the year-end; this is a reduction of approximately 3% on the previous year. Of this estimated population approximately 49% attended a clinic at least once during the year and this can be broken down to show that 68% of the 0 – 1 year age group, 73% of the 1 – 2 year group and 33% of the 2 – 5 age group made at least one attendance at the local authority clinics. Birthday cards containing a programme of clinic sessions and suitable health education material are posted to all children aged 1 and 2 years who are known to reside in the City.

Medical staff attended 49% of the Child Health and Welfare Clinics and the figures show that 15.3% of children's attendances in the 0 – 1 age group, 14.9% of the 1 – 2 age group and 31.1% of the 2 – 5 age group attendances also included medical consultations. As was to be expected with fewer medically staffed sessions, there were fewer referrals for advice or treatment.

The figures relating to attendances and medical care are set out below:–

AGE GROUPS – CLINIC ATTENDANCES

Age Group	Estimated Salford Population	Individual Attenders during year	% of Salford Age Group	Total Attendances during year	Average Attendance per Child Attending	Medical Consultations	% of Clinic Attendances	Referrals Elsewhere	% of Medical Consultations
0 – 1 year	2,676	1,815	68%	11,820	6.5	1,810	15.3%	71	3.9%
1 – 2 years	2,696	1,957	73%	10,913	5.6	1,629	14.9%	94	5.8%
2 – 5 years	7,257	2,421	33%	5,554	2.3	1,726	31.1%	254	14.9%
0 – 5 years	12,629	6,193	49%	28,287	4.6	5,165	18.3%	419	8.1%

Specialist clinics staffed by hospital consultants are held on local authority premises and sessions have been arranged for premature babies and paediatric and orthopaedic consultations. Attendances at the premature baby sessions have been similar to the previous year, but attendances at the paediatric sessions have fallen considerably; the orthopaedic sessions, while recording the same number of children as the previous year, have dealt with more follow-up attendances and have been much busier.

Co-operation with the hospitals has continued to be good and many hospital reports have been received. During the autumn, Hope Hospital started to issue a combined report on the condition of both mother and baby on discharge from the maternity unit; should the baby be retained in hospital after the mother is discharged a following report is received when the child eventually leaves hospital.

Migration still necessitates considerable follow-up work for all staff concerned with infants and young children. Children who remove with their families to unknown addresses are a great concern to us as they may well be lost to child welfare care either in another town or even within this City. Many records for untraced children are matched up with school health records when their names appear on school admission sheets for the City. During the year 977 children's records were forwarded to other areas and 696 portfolios filed pending request for them; 762 children were known to have moved into the City and records from other authorities relating to these children were received.

WELFARE AND PROPRIETARY BRAND FOOD SALES

Sales of National Dried Milk dropped this year to 21,297 tins, (26,529 in 1965), mothers apparently preferring to take their milk subsidy in the form of liquid milk. Sales of proprietary dried milk foods have been steady, the cheaper brands being the most popular. There has been a notable increase in the sales of evaporated milk, no doubt due to the fact that many babies discharged from Hope Hospital Maternity Unit are already having this type of food when discharged from the hospital. Five dried and two evaporated milks are stocked as well as National Dried Milk so that mothers may purchase the food of their choice at the clinics.

At the end of the year, 13 types of cereal foods made by five manufacturers, were stocked in the clinics to encourage and enable mothers to vary the diet.

Fourteen proprietary preparations containing vitamins and/or minerals are stocked and there has been a steady sale of these items, Vitamin C syrups being particularly popular.

The sales of Ministry of Health Vitamin preparations have fallen continuing the decline in these sales which has been apparent since 1954.

Preparation	Year	Sales	Estimated Uptake
Orange Juice	1966	30,331 bottles	7.68%
	1965	31,663 bottles	7.8%
Cod Liver Oil	1966	2,483 bottles	2.45%
	1965	2,547 bottles	2.6%
Vitamin A + D Tablets	1966	3,977 packets	15.43%
	1965	4,835 packets	17.90%

Approximately 8% of National Dried Milk, 19% of Cod Liver Oil and 17% of Vitamin A + D Tablets have been issued free of charge this year.

Again our thanks are due to the Women's Royal Voluntary Service who staff the Welfare Foods Distribution sessions at the Hope Hospital Antenatal Clinic.

DENTAL SERVICES

Small children have an awful lot of bad teeth. They eat too many sweets and the really young ones have their teeth constantly bathed in sweet vitamin syrups. If parents can be persuaded to reduce the quantity of sweets their children eat and be not so indulgent with sweet syrups, we would reduce the rate of dental caries substantially. As it is, in 1966 we extracted 444 teeth from children not yet at school; the majority of these children had had severe toothache before visiting us. We hope in the future to save a good many of these children from such an ordeal by more frequent inspections and earlier treatment and we are starting with inspections and treatment at the nursery schools.

There has been a marked reduction in the number of expectant and nursing mothers treated at our clinics since free treatment for these patients became available through the general dental services. In 1966 we saw 94 patients, filling 31 teeth and extracting 67 teeth. 8 patients were fitted with dentures.

MEDICAL REPORT ON DAY NURSERIES

During the year a Medical Officer made 21 visits to the three Salford Day Nurseries and a total of 342 medical examinations were carried out; of these 99 were primary examinations on new admissions to the nurseries and 243 were re-examinations. The general health of the children appears to be good and during the year there were no major outbreaks of disease, apart from the usual crop of catarrhal colds and a few cases of infectious illness e.g. measles, chicken pox, etc.

The defects found by the Medical Officer were the usual ones, namely dental caries, enlarged tonsils and genu valgum. One child has an artificial leg but she is not handicapped in any way by this and she is able to run and jump and join in all the activities of the nursery.

Following the mild outbreak of Variola Minor in Salford in July 1966, smallpox vaccination was offered to the children in the Day Nurseries and 35 children were vaccinated in the nurseries by the visiting Medical Officer.

In addition to the three local authority day nurseries, the Medical Officer also visited two privately-owned day nurseries. One of these is attached to a rainwear factory and provides day nursery care for young children of mothers working in the factory. The number of children in this nursery is small and numbers vary according to the season of the year, e.g. there are more children in the nursery during November and December than at any other time. There is a very rapid "turn over" of children in the nursery and only six children were examined more than once. Eighteen children were examined once and three children were not examined at all, because they were in the nursery only a very short time. All the children appear to be happy and well-cared for and there have been no outbreaks of infectious disease during the year.

The private nursery school in Higher Broughton has also been visited by a Medical Officer on two occasions. This is a Nursery School (registered as a private day nursery) for orthodox Jewish girls and twenty-three children were examined, six of them on two occasions. The health of these children is good and no physical defects whatever were found.

REGISTRATION OF PRIVATE DAY NURSERIES

Under the provisions of the Nurseries and Child Minders Regulations Act, 1948 the following premises are registered with the local health authority :—

1. 4, Hilton Street, Salford, 7. These premises are owned by a rainwear manufacturer and are used as a private Day Nursery for the children of his employees.

2. 21, Wellington Street East, Salford, 7. A private Nursery School for orthodox Jewish girls is run on these premises.

3. Cleveland House, Eccles Old Road, Salford, 6. The Bambi Playgroup meets at Cleveland House regularly each week, the premises being hired from the local authority for this purpose.

4. The Height Methodist Church School Hall, Bolton Road, Salford, 6. A playgroup run by a committee of mothers is run on these premises under the auspices of the Methodist Church.

5. Holy Angels Church Hall, Sumner Road, Salford, 6. A playgroup run by a committee of mothers under the auspices of the Parish Church is held on these premises.

The children who attend the playgroups are not medically examined as they are not out of the care of their parents for more than two hours per day.

PLAYGROUPS

It is with regret that I have to report that the four playgroups organised by the local health authority were closed on Wednesday, 12th, October 1966.

The closure of the playgroups was forced upon us because the Ministry of Health refused to allow expenditure of public money on projects of this nature, although it is widely believed that such groups play an important part in the prevention of behaviour disturbances and the promotion of good mental health in young children ; particularly children who are deprived of essential play experience because of the lack of play facilities within the home or the environs of the home.

Both the parents and the children who had attended the various playgroups were greatly upset by the closure of the playgroups and by the end of the year, steps were being taken by mothers in the neighbourhoods of Kersal Centre and Summerville Clinic, to start private playgroups.

VOLUNTARY ORGANISATION MOTHER AND BABY HOMES

There are two voluntary Mother and Baby Homes in Salford. Both Homes are visited at regular intervals by members of the staff of the Health Department.

It is apparent that in both Homes every effort is made to prevent

infection occurring, and both homes maintain exceptionally high standards of cleanliness.

There is close co-operation between the staff of both homes and the staff of the Health Department.

ADOPTION MEDICAL EXAMINATIONS

During the year, seven infants and young children were examined under the regulations of the Adoption Act 1958 by Medical Officers on the staff of the Health Department and, in each case, the child was reported to be suitable for adoption.

In addition to this an unspecified number of children were medically examined at the request of the Children Officer, prior to their being admitted into the care of the local authority. These arrangements are made informally between the Child Care Officer concerned and the Medical Officer on duty at the most convenient clinic.

CERVICAL CYTOLOGY

During 1966 there was a total of 1,330 attendances at local authority Well Woman Clinics. This number includes 325 three-yearly repeat tests, 187 other repeat tests and 25 cases in which a smear was not taken for some reason; the remaining 793 were attending the clinic for the first time. It is of interest to report that we are co-operating with the Manchester Regional Hospital Board in a research project and 31 of the repeat smears were taken at the request of the Board for this purpose.

Only 6 women were found to have malignant cells in their cervical smears and all were referred by their family doctors to a Gynaecologist for treatment. There were also 2 smears which were reported to show "doubtful" malignant cell changes and these women were also referred for gynaecological opinion.

There were several new developments in the service during the year. The most important was the training of a small group of Queen's District Nurses to take cervical smears. The nurses visited the homes of women who were unable to attend the clinic for some reason or other and they also attended the Annual Health Check-up in July and August 1966, and took smears from those women who were willing to have the test immediately, without waiting for an appointment at the clinic. In total, the Queen's District Nursing staff took 286 smears – 36 on the district and 250 at the Health Check-up.

Another new development was routine urine testing for glucose, in an attempt to identify previously undiagnosed diabetic women. Three women were found to have glycosuria, but all knew they were diabetics and in fact no new cases were identified. This work, however, will continue in the future.

As in previous years the breasts of the women attending the clinics, were examined for early cancers of the breast, and women were also advised to examine their own breasts at regular intervals.

During these examinations six women were found to have a small lump in the breast, and in each case the woman was advised to consult her family doctor. One patient attending for a three-yearly repeat test reported that she had herself found a lump in her breast one year previously and that she had consulted her own doctor immediately who arranged for surgical treatment within a week.

During the year the number of non-Salford residents who attended for a cervical smear was 132. In 1965 there were 266 non-Salford residents. This fall is due to the fact that facilities for cervical smear tests are now available much more widely.

The importance of early detection of cancer of the cervix cannot be stressed too strongly and the Ministry of Health Circular 18/66 has given added impetus to our efforts in this field.

PHYSIOTHERAPY

During the year physiotherapy and ultra-violet light treatment clinics have been held in conjunction with all the child welfare clinics in Salford.

Compared with the number of school children on treatment, the number of children under five referred for treatment has been extremely small, especially those suffering from minor orthopaedic defects, thus giving rise to thought as to whether or not these conditions do not develop until after school age or are not being discovered until a later age when the children are examined by a school medical officer.

Fortunately, babies with more serious congenital conditions are usually referred for physiotherapy during the first year of life. This is most important because it is only by early treatment that lasting deformities can be prevented and a child enabled to lead as full a life as possible within the limitations of its handicap.

During the year, 152 children received 2,735 physiotherapy treatments, and 46 children received 480 ultra-violet ray treatments at the various clinics.

As there is no nursery accommodation for handicapped babies, in a small way a once-weekly session for treatment and constructive play has been started at Langworthy Clinic. Some friends have kindly donated a few toys, but so far it has only been possible to have ambulance transport for two mothers and babies but several more would greatly benefit if only a little more transport were available. Many parents of handicapped babies feel very isolated in their trouble, and it helps them a great deal to see there are other babies with handicaps similar to their own and to have a friendly chat with other mothers.

Children attending the day nurseries have received physiotherapy treatment in the nursery because in most cases the children attend the nursery for social reasons, and it seems wrong that a child should be penalised because there is no one available to escort the child to a welfare clinic.

Children who attend the day nurseries received 36 ultra-violet ray treatments and 309 physiotherapy treatments from the physiotherapists visiting the nurseries.

Treatment in the mental health centres is still very difficult because of the shortage of accommodation which makes working conditions difficult for everybody. During the winter months, from September to March, the children at the Special Care Unit, Wilmur Avenue Centre, have been given a course of ultra-violet light and it is felt that this has helped the catarrhal nasal conditions from which so many of these children suffer. 389 ultra-violet ray treatments and 1,021 physiotherapy treatments were given to children at this centre.

A weekly physiotherapy session for men, and another for women have been held at Langworthy Clinic, in conjunction with the medical officers Geriatric Clinic held there. A once-weekly session has also been held at Regent Road Clinic, and wherever possible the physiotherapists have treated a senior citizen at the end of a child health session so that an elderly patient could be spared a long bus journey.

Elderly people treated at the physiotherapy clinics have received 1,494 treatments, which seems a large number but this is because so many of them not only receive heat and massage for stiff shoulders and backs but often stiff knees and ankles as well. These clinics fulfil a social as well as a physical need. Unfortunately it is very difficult to discharge the patients, especially when they are like the man of 84 who says he would be in a bath chair if it were not for his weekly physiotherapy treatment. The hospital told him ten years ago they could do nothing further for him.

There is a great need for a physiotherapy service to visit handicapped people in their homes to advise the patients themselves and their relatives on how they may remain active at home and not become bedridden with the resulting conditions of bronchitis and incontinence. Hospital visits with long cold waits for ambulances are not the answer because old persons need to be seen in their own environment so that home conditions can be adapted to their special needs. Well-equipped physiotherapy departments are too remote from the home conditions. Unfortunately, there appears to be no money available for this service, which would ultimately save the health service a great deal of money in nursing, and ancillary services, to the bedridden, as well as the human element of making the last few years of life more happy and independent.

During the year, the physiotherapists have visited 44 handicapped, usually elderly, patients at home but it has only been possible to make infrequent visits, usually during school holidays when a little more time is available. A wider granting of car allowance would help, as much time and energy is wasted in waiting for infrequent buses.

FAMILY GUIDANCE CLINIC

The Family Guidance Service has continued to be available to help the child and family where an emotional disturbance is present. The broad categories of presenting problems remain the same as stated in previous reports – that is marital disharmony, maladjusted children and a very small number of psychotics. In the first group the neuroses are the most prominent and sexual difficulties are also a frequent cause of referral. The children are seen either through the direct agency of a Child Health Clinic brought by a parent at their own instigation or at the request of a head teacher, health visitor or any social worker concerned with the welfare of the family. It should be mentioned here that a close liaison is maintained also with the Child Guidance Clinic for more seriously disturbed cases. Family guidance, as its name implies, is essentially concerned with family attitudes – to explore with the parent of a disturbed child or the partner of an unhappy marriage where his attitudes are creating many of the difficulties and how these have developed through his own childhood experiences and then helped to adjust to the needs of the family and society. Often the most disturbing member of the household is genuinely unaware that his personality traits are the focus of the trouble. Unfortunately, there is also frequently a wide disparity between the intellectual recognition of the need for improved standards of behaviour and the emotional stability and discipline to maintain them. This is particularly the case when faulty attitudes have embedded themselves in the personality as occur with so many adults, when much help over a long period is needed to sort out the problems.

In the past year there has been an increase in the number of married women suffering from anxiety neurosis because of the triple burden of family, home and outside job – particularly where the husband is content to let his wife assume this burden and gives little or no support. In these families the husband is the weaker character and is either unemployed or in irregular employment and all too readily opts out of any of his responsibilities. Unfortunately this negative attitude not only puts extra strain on the wife but makes the job of child rearing so much more difficult, particularly as the adolescent years are reached.

Another type of personality which frequently leads to emotional disturbance and unhappiness in family life, is when one partner has a very rigid and inflexible approach with maybe high standards of morality and behaviour but unable to give out much warmth and kindness in their relations with others. The self-righteousness in such people can be so great that they are not prepared to make any adjustment to family and society, expecting everyone to conform to their requirements as they feel so totally in the right. It is a very difficult and uphill task to dent this psychological armour and often a crisis has to occur in their experience before any change of attitude will occur. Again a persistently belligerent aggressive approach in a parent can lead to hostile, delinquent and maladjusted children.

These then are some of the examples of the adult attitudes disturbing the family life which must be modified to enable effective and lasting improvement to be maintained in family relationships.

Finally, thanks must be given once again to the various social workers and others involved in any referral, for it is without doubt the close liaison and ease of communication that exists between us, which not only benefits the family concerned but ourselves too in the broadening of our own understanding and sympathy.

CONVALESCENCE

Nineteen requests – sixteen covering adults (8 men and 8 women), two young children, and a mother with 5 children, were received during the year. All the adults gave a history of prolonged sickness and/or unemployment, low pensions or allowances and stated their inability to pay towards the cost.

Assistance was given as follows :–

11 adults (including a husband and wife) were advised as to the procedure regarding help from the Cotton Towns District Fund.

1 adult who was suffering from a bad attack of bronchitis was referred to the Civic Welfare Department for placement at Southport.

1 aged person was referred to the Civic Welfare Department via the Health Visiting Department.

1 adult attending Hope Hospital chest clinic was eventually placed by the Hospital in a Hospital Convalescent Home in Yorkshire.

2 mothers from problem families were placed for convalescence at St. Annes-on-Sea via the Cotton Towns District Fund. Just before they were due to go they were admitted to hospital and did not seek a further placement on their return home.

2 children (4 years of age) were referred to the Invalid Children's Aid for a 4 week period at Abergele, one child did go but the parents withdrew before the other child went away as they considered that he was fretting at the thought of going.

It was not possible to send a problem family (mother and five children) away due to the high cost incurred and the fact that although a high income was received in the house no contribution to the cost was likely to be received.

GERIATRIC GUIDANCE SERVICE

The geriatric guidance clinics were continued at Regent Road Clinic and Langworthy Centre. In the latter part of the year clinics were also held at Kersal Centre and Police Street Clinic.

In the future it is hoped to develop these clinics, which provide a health check-up for the elderly, so that they are within reach of more persons of pensionable age.

It is envisaged that these geriatric health clinics should have four functions :–

1. A centre for the physical and mental health "check up" of persons of pensionable age. A medical examination specifically directed to the early detection of diseases and disabilities of the aged to be carried out by a medical officer.

2. A centre for social health "check up" of old persons, particularly those living alone.

3. A point of reference for the health visiting and other services provided by the health department. When family doctor teams, with the health visitors and nurses attached, are in existence the initial point of reference will be the general practitioner although as the geriatric health clinics become more developed and specialised themselves, it may be that general practitioners will find such clinics a useful reference point for particular problems.

4. As a centre for socio-medical follow of patients discharged from hospital who do not need to attend hospital geriatric departments for consultant medical supervision.

At present the geriatric health clinics are intended to supplement the existing general medical services and to help general practitioners in the total care of their elderly patients; they are primarily preventive and diagnostic and not therapeutic.

Attendances

There were 348 attendances during the year; 214 elderly persons were seen, their ages ranging from 62 to 91 years. Of these, 144 attended for the first time – an increase on the previous year and in keeping with the future policy of encouraging the elderly to attend for a health check up in the early years of retirement.

Females attending

Total female attendances – 213
Persons seen – 131
First visits – 90
Age range – 62 to 84 years

The clinics for females were held at Langworthy Centre and Regent Road Clinic.

The complaints suffered and diseases found included:– arthritis (all forms, 25), cardiac and respiratory disorders (21), hypertension (16), obesity (14), digestive disorders (9), anaemia (8), deafness (8), and various gynaecological disorders (8). Many of those seen had defective vision, unsatisfactory dentures, and some required chiropody.

Only 19 of the 131 persons seen were considered to be wholly "fit and well" but too much significance must not be attached to this figure because at present those invited to attend the clinic are in themselves a selected group, having initially been referred to the health department for one or other of its services for the elderly.

Simple blood tests for the detection of anaemia were carried out on 11 patients although this facility was not available at all clinics. Arrangements were made for 9 women to have their ears syringed to remove wax; for 7 to attend the chiropodist, and 22 were referred for physiotherapy. Where defects or diseases not receiving treatment were found the women were advised to consult their family doctor; in some cases arrangements for the women to see a specialist were made after consultation with the family doctor.

Nutrition continues to be a major problem in the elderly due to lack of inclination to be bothered to cook for oneself when living alone and to lack of finance. Those with obesity were given dietary advice but it is often difficult for pensioners to follow this because the high protein/low carbohydrate diet recommended is too expensive for them to follow. Similarly those advised to have special diets because of digestive disturbances, e.g. peptic ulcer, find this hard to follow because of the expense.

Males attending

The clinics for males were held at Langworthy Centre and Regent Road Clinic with some sessions also at Kersal Centre and Police Street Clinic in the last four months of the year.

Langworthy Clinic

There were 86 attendances at Langworthy Clinic; 29 males were seen, of whom 6 had attended for the first time. The complaints suffered and diseases detected included arthritis and fibrositis (all forms, 12), cardiac and respiratory disorders (14), deafness (5), visual defects (2), and depression or anxiety (2).

A high proportion (23) men were referred for physiotherapy at this clinic where this service has been established for the elderly for some years. Arrangements were made for 5 men to have wax syringed from their ears and 3 were referred to the chiropodist.

Eleven of the persons seen at Langworthy Clinic were referred to hospital consultants following consultation with the general practitioner.

Male Clinics at Regent Road Clinic, Kersal Centre and Police Street Clinic

The policy at the clinics held at these centres during the last four months of the year was to take a critical look at our work with a view to developing it to fulfil the four functions described above.

Total attendances – 49
First Visits – 38

The complaints suffered and diseases detected at these clinics included deafness (13), visual defects (12), hypertension (13), cardiac disorders (10), respiratory disorders (6), alimentary tract disorders (6), osteo-arthritis (5), and genito-urinary disorders (5). There were 10 men who had hernias but all but two of these were satisfactorily controlled by trusses.

Only 3 men were referred to hospital consultants after consultation with their general practitioners, but 19 of those seen were advised to consult their own doctors for one reason or another.

Arrangements were made for 9 males to have their ears syringed. Although a very minor disability, deafness due to wax in the ears causes many old persons distress and this service was much appreciated by the elderly.

The above figures do not include males seen at Regent Road Clinic prior to August for whom no details are available.

Initially these clinics were continued on the existing lines but it was evident that they should not become an alternative to the family doctor through which the elderly could obtain treatment or reference to a hospital consultant. It is the general practitioner's function to treat established disease and refer patients to specialists when this is necessary.

The geriatric guidance clinics should provide a facility that the family doctor is at present unable to give. They should assist him in the care of his elderly patients on a long-term basis by the practice of preventive medicine, health education and the early detection of disease by a health check-up specifically designed to establish whether the aged person's physical, mental and social health is as good as it can be. In the aged there is an ever-present danger that symptoms due to treatable and curable disease are dismissed as just due to old age.

INCIDENCE OF BLINDNESS

A1. Registered Blind Persons

A2. Registered Partially Sighted Persons

B. Ophthalmia Neonatorum

Blind Person

A1. FOLLOW-UP OF REGISTERED BLIND PERSONS

Total number of cases registered during 1966.....39

(i) Number of cases registered during the year in respect of which Section F. (1) of Forms B.D.8 recommends :—	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(a) No treatment	7	3	—	19
(b) Treatment :—				
Medical	—	—	—	—
Surgical	2	—	—	1
Optical	—	—	—	1
Ophthalmic Medical Supervision	2	—	—	4
(ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment			8	

A2. FOLLOW-UP OF REGISTERED PARTIALLY SIGHTED PERSONS

Total number of cases registered during 1966.....10

(i) Number of cases registered during the year in respect of which Section F. (1) of Forms B.D.8 recommends :—	Cause of Disability			
	Cataract	Glaucoma	Retrolental Fibroplasia	Others
(a) No treatment	—	—	—	—
(b) Treatment :—				
Medical	—	—	—	1
Surgical	2	—	—	—
Optical	—	—	—	—
Ophthalmic Medical Supervision	2	1	—	4
(ii) Number of cases at (i) (b) above which, on follow-up action, have received treatment			4	

B. OPHTHALMIA NEONATORUM

(i) Total number of cases notified during the year	Nil
(ii) Number of cases in which :—	
(a) Vision lost	Nil
(b) Vision impaired	Nil
(c) Treatment continuing at end of year	Nil

HEALTH VISITING SERVICE

The service continued to cover a comprehensive range of duties in relation to general health visiting/school nursing/and specialised services.

Work in relation to the Happy Family Survey was undertaken throughout the year and in all 2,792 blood tests were taken. The acceptance rate in this survey has been very high and says much for the good relationships existing between the health visitors and the general public.

The number of health visitors attached to Family Doctor Health Teams has increased, and it is now possible to see some of the results of this improved co-operation. Two health visitors are assisting the doctors with the identification of high risk groups and have made a start by following up the relatives of known diabetics. Once again public response has been encouraging; one mother who was given urine testing strips for the family co-operated to the extent of sending one to her son in Scotland!

A new coding system for the visits made by the health visiting service staff was devised when it was known that some computer time was available and all visits from the beginning of October were dealt with in this way. An analysis of the figures for the quarter brings some interesting information to light which would not otherwise have been readily available without this mechanical help.

Ancillary Help

The value of ancillary help has been appreciated in this service for many years; both clinic nurses and nursing auxiliaries assist the health visitor in her work. Considerable help of this kind can be used without diluting the work of the health visitor; indeed the reverse is true, the health visitor who is relieved of work which does not require her training, can deal more adequately with the more pressing health and social problems, and is more likely to have job satisfaction.

Staff

A valued member of the staff was lost to the service when Mrs. D. Appleby, Assistant Superintendent Health Visitor, had to retire because of ill-health. Mrs. Appleby, who served the Corporation for 25 years in different capacities, held several senior posts in the Health Visiting Section before being appointed Assistant Superintendent in 1965 and never failed to distinguish herself in her role; her wealth of experience is not easily replaced.

SPECIALIST HEALTH VISITOR SERVICES

(I) HOSPITAL LIAISON

Liaison has followed an established pattern in the main, but certain aspects of the work have been modified or developed according to need.

(a) Paediatrics

Hope Hospital

The demolition of slum property in the City and removal of families to over-spill estates has been reflected by a decrease in the number of Salford children attending the out-patient departments, and in consequence this aspect of liaison has been reduced. On the other hand liaison with the Maternity services' staffs has increased and in particular with the staff of the special care unit who are concerned with babies "at risk". Information concerning 2,576 children who were either in-patients or out-patients during the year was passed to area health visitors. The liaison health visitor made domicilary visits throughout the year for special reasons and when the need for information was urgent or the area health visitor was absent.

Ladywell Hospital

Because of the happy reduction in infectious diseases, liaison in this context has decreased. In October, A2 ward ceased to be used for children suffering from infectious diseases and liaison is now confined to A1 ward only. Weekly contact is maintained, and requests for help are received and dealt with at any other time should the need arise.

Royal Manchester Children's Hospital

The medical wards have been visited once a week and the surgical wards occasionally.

Gartside Street Out-Patient Department — R.M.C.H.

A very satisfactory relationship developed during the last year, the weekly contact being appreciated on both sides. It is here that the more pressing problems of failure to maintain follow-up after care arise and therefore the liaison health visitor can be of great help. There are still parents who do not appreciate the need to present their children for continued medical supervision, and who allow recommended treatments and medication to lapse. Many families are frequently on the move to other parts of the City; these are traced if at all possible and encouraged to continue attendance at the out-patient department.

(b) Diabetic Clinics

The greatest value in this liaison lies in the support offered to the newly diagnosed diabetic, during the difficult early days when the patient has much to learn about the management of a diet, the care of health generally, and possibly the administration of a daily injection of insulin. That continued help is often needed is shown time and again from the situations found by the liaison health visitor in the course of visiting.

One man, a 'bus driver, required help with his diet because of his shift work and the need for packed lunches. Another man having "hypo" attacks was found to be using insulin that was 12 to 18 months out of date. A woman who was reluctant to attend the diabetic clinic required long and frequent

visits to establish good management. One old lady had to be visited after every change of insulin and required written instructions to help her; she also needed to be reminded regularly not to delay or miss meals. Many patients were found to be confused about diet and/or miscalculating doses of insulin and would have been in difficulties without the service provided.

Salford Royal Hospital

Number of new patients referred	8
Number of patients already being visited	25
Number of patients non-diabetic	1
Number of home visits made	95

Hope Hospital

Number of new patients referred	31
Number of patients already being visited	45
Number of patients non-diabetic	1
Number of home visits made	175

Miscellaneous Visits from other sources

Visits to 4 children referred by R.M.C. Hospital	13
Visits to expectant mother referred by St. Mary's Hospital	1
Visits to child referred by Booth Hall Hospital	5
Visits to adult referred by Mental Health Department	1
Visits to adult referred by Northern Hospital	1
Visits to adult referred by Ladywell Hospital	1
Visits to adult referred by Clinic Nurse	1
Visits to adult referred by Consultant Physician	1
Total number of visits to diabetics	294

(c) Chest Clinic – Tuberculosis and other Chest Diseases

During the year, 71 cases of tuberculosis were notified compared with 45 cases last year; 5 of these were non-respiratory conditions. More cases were notified from Salford, 5 and 7 areas than from other parts of the City. Of the 71 notified, 25% were men and women over 60 years of age and 7.04% were young children. The reasons for the increase in tuberculosis are not yet apparent.

Contact tracing and regular medication were the main concern of the liaison health visitor. As a result of contact tracing, four cases were discovered in one family and in another both husband and wife were found to be infected. Personal interviews were continued at the Chest Clinic and at

Ladywell Hospital as during the previous years. Patients were also visited in hospital whenever admission was from other sources than the Chest Clinic.

In relation to patients with other chest conditions such as lung cancer or bronchitis, the liaison health visitor was mostly concerned with problems related to hospital admission, loss of work, rehabilitation and health education. Both patients and relatives required support, especially when faced with a long or terminal illness, and domiciliary follow-up was undertaken when appropriate. The co-operation of the Disablement Resettlement Officer and the staffs of the Home Nursing Service and the Ministry of Social Security was of great value in this work.

At the Bronchitis Unit regular discussion of the problems which arise out of hospital discharge took place with the Consultant Staff. The aid of various social services, particularly those of the Local Authority, was obtained whenever required with the aim of good after-care of the bronchitic patient; this is of the greatest importance as the shortage of hospital beds in this branch of chest disease is very acute indeed. Special difficulties were encountered when the patient was an unwanted, aged chronic bronchitic and the staff undertaking the care of the elderly were able to give assistance with these cases.

(2) CARE OF THE ELDERLY

Early in June, a medical officer who undertakes duties for both the Local Authority and the Regional Hospital Board, accompanied by the Specialist Health Visitor for the care of the Elderly, commenced domiciliary visiting on a weekly basis so that priorities for admission to hospital could be established. The health visitor's role is to provide background information to assist the doctor to determine priorities and, as has been the practice for many years, to arrange for maximum help in the home in the event of delay in admission. 198 patients have been visited since the start of the scheme.

Geriatric Guidance Clinics

The number of Geriatric Guidance Clinics was increased during the year. Health visitors and SRN's encouraged the old people to attend, and were present at these clinics to support the doctor's medical examination by health education and discussion of problems.

Nutritional Deficiencies

An apparent increase in the number of elderly persons found to be suffering from some degree of malnutrition gave cause for concern. Several factors appear to have a bearing on these findings, not least being the cost of meat and vegetables. Another possible cause is that many old people have ill-fitting dentures or wear no dentures at all and spend so much time chewing on one piece of meat that the remainder of the meal becomes cold and remains uneaten; others are encouraged to choose soft starchy foods because of dentures which have ceased to be comfortable and effective. Many old people are unwilling to persevere when new dentures are provided, and some would only obtain treatment if a service were brought to them in their own home. Other factors contributing to the lack of a satisfactory diet are inability to

undertake shopping personally, apathy and loneliness, and poor cooking facilities. Apart from cooking difficulties, these problems are intensified when old people are re-housed in flats away from their old area. Many have lived all their lives in one neighbourhood and have been limited to a small circle of friends and neighbours. In some cases, a friendly chat by the door has been replaced by a vista of chimney pots.

Supportive Services

The bathing and foot hygiene service undertaken by nursing auxiliaries continued to give good support to the work for the elderly, and other help from both statutory and voluntary sources was enlisted, one example of voluntary help being that of a group of students who did gardening or decorating for some of the elderly persons.

Particulars of age, sex and type of referrals are given in the following tables :–

Number on Register

	New cases notified in 1966	Carried forward
Males	389	825
Females	785	3,347
	1,174	4,172

Grand Total 5,346

Age Groups — New referrals

60 – 64 years	210
65 – 69 years	269
70 – 74 years	273
75 – 79 years	172
80 – 84 years	109
85 – 89 years	51
90 + years	30
Under 60 years (handicapped)	60
	1,174

State of Activity

Bed-ridden	248
House-bound	202
Semi-ambulant	262
Ambulant	462
	1,174

Sources of referral

Civic Welfare	56
Found in the course of visiting	126
Family doctors	92
Health Visitors	39
Home Help Section	28
Hospitals	154
Mental Health Section	4
Relatives and friends	180
Public Health Inspectors	9
Voluntary organisations	33
Housing Department	75
Other statutory agencies (chiefly district nurses)	378
	1,174

(3) SOCIALLY HANDICAPPED FAMILIES – Prevention of Family Break-up

At the end of the year, 256 families were on the problem family register and 358 were listed as potential problem families. These figures, which indicate the number requiring long supportive help, do not however signify the amount of time and effort devoted to the prevention of family break-up and the degree of success achieved in other cases. Many families that are referred at a time of crisis are helped to find a satisfactory solution to their problems, and although it is true that some of these families are found to be involved in another crisis at a later date, for others it is possible by help at the right time to prevent further deterioration.

The Specialist Health Visitor continued to work closely with many voluntary and statutory agencies – attended case conferences throughout the year and met representatives from Children, Housing and Welfare departments to discuss the problem of families in arrears of rent; discussed cases with area health visitors; visited 163 individual families throughout the year five of whom received intensive visiting and made 755 visits in all.

Office Consultations

During the year, 142 members of the public sought office interviews with the Specialist Health Visitor for the following reasons :–

Housing and accommodation problems	25
Care of children	8
Help regarding clothing	18
Financial difficulties	40
Medical help	4
Marital problems	28
Convalescence	3
Miscellaneous	16

As is usually found, these were only the presenting problems and other difficulties were subsequently discovered.

Prisoners' Families

29 families involving 71 children were visited during the year following notification by the Prison Welfare Officer at Strangeways, the visits being made as early as possible after notification. Some wives were found to be quite overwhelmed by their situation, but fear of condemnation from neighbours prevented them from seeking local help and support and they were glad to be visited. Assistance was given in relation to budgeting, particularly where there was an accumulation of hire purchase commitments, and visiting was continued after the husband's discharge from prison until he obtained employment. The health visitor has the advantage of not being connected with the Courts and because of this her help was well accepted. A multiplicity of help is usually required for the wives of prisoners. A young woman with three children aged 1, 2 and 3 years, nervous and in need of medical help, with debts, strained relationships with her in-laws, and without cooking facilities other than a hazardous open fire until the Specialist Health Visitor obtained a second-hand cooker for her, is typical of the type of case encountered.

Day Training Centre

An average of six mothers and their children attended each session. Referrals were made by health visitors, child care officers and probation officers.

In addition to the need for instruction in domestic skills required by all the mothers, some are found to have special difficulties to overcome. There is little point in telling a woman how important it is to shop wisely and to follow simple economical recipes if she is illiterate. One woman of 36 was taught to read and write by the domestic science teacher before she could benefit from the instructions offered. Aggression is commonly encountered in new mothers and they need skilful handling to enable them to settle down in the group.

It was still not possible to recruit voluntary help for the purpose of escorting mothers and children to and from the centre, so that attendances could be maintained and the number of mothers involved increased. Assistance was given by students of the Royal College of Advanced Technology to decorate parts of the centre.

Woden House Play Group

The need for play facilities for children in the Regent Road area who live in flats has been felt for some time and by presenting this idea to members of the International Voluntary Service and obtaining permission from the Housing Committee to use the basement of Woden House, it was possible to start this venture in June. The play group is held each Saturday morning for children between 5 and 11 years and provides a safe place in which to play and an opportunity to enjoy shared purposeful activities. Considerable voluntary help has been organised by the International Voluntary Service and this includes sixth formers from local schools, college and university students. Funds were raised in various ways by the Specialist Health Visitor and the volunteers.

Interest in the centre has never flagged on either side. 40 children have enrolled for the centre and the average attendance is 28. Arrangements have been made to hold a two-week international work-camp during August when the usual volunteers are on holiday, so that the centre can continue to function at a time when it will be most needed. The students hope to arrange various outings of interest for the children and group activities will take place on week-days also.

THE UNMARRIED MOTHER

It is generally accepted that the illegitimate birth rate in industrial areas is higher than the national average. The Registrar General's figures for 1965 show Salford's rate as 11.56% of total live births against the national average of 7.7%. When one takes into account, however, that two hostels for unmarried mothers and their babies are within the City boundaries, and that many of the mothers live outside the area and take up residence in the hostels only a few weeks before the birth of the baby, the picture of the illegitimate birth rate among Salford residents is somewhat brighter than it appears at first glance. It is true, of course, that a certain number of Salford girls go out of the City to have their babies, just as others come in and some may make private arrangements not known to us, but only 12 applications for financial assistance for hostel accommodation outside the City were received during the year, whereas the number of illegitimate births notified from the two hostels in the City was 114; of these, 9 only were Salford girls.

Of the 2,802 adjusted live births for 1966, 317 (11.27%) were known to be illegitimate, but if this number is adjusted to exclude the births relating to girls in the hostels who are not Salford residents, the number of live births is 2,697; of these 212 are illegitimate, giving a percentage of 7.86% born to Salford girls.

As the following tables show, 81.6% of these girls kept their baby and only 10.52% of these were without the support of the putative father or relatives.

Civil Status of mother

Single girls	146	69.5%
Married or married separated women	55	26.2%
Widows	1	0.5%
Divorcees	8	3.8%
	210 (2 sets of twins) = 212 babies	

Parity of mothers

First child	139	66.2%
Second child	18	8.6%
Third child	22	10.5%
Fourth child	17	8.1%
Fifth child	4	1.9%
Sixth child	5	2.4%
Seventh child	2	1.0%
Eight child	1	0.5%
Ninth child	1	0.5%
Tenth child	1	0.5%

Subsequent Care of Baby (212 babies)

Placed with foster-mother in residential care	15	7.1%
Placed with foster-mother awaiting adoption	16	7.5%
Cared for by grandmother or other blood relative	4	1.9%
Deaths	4	1.9%
Remaining with mother	173	81.6%

Position of Mothers keeping their Baby

Subsequent marriage	4	2.3%
Cohabiting with putative father	92	53.8%
Living with parents	52	30.4%
Living with other relatives	5	2.9%
Living in rooms without support from family or putative father	18	10.5%

Civil Status of Putative Fathers cohabiting with Mother

Single	14	15.2%
Married and separated	46	50%
Divorced	4	4.3%
Not disclosed	28	30.4%

TRAINING OF STUDENTS

The Section provided lectures and/or visits of observation for the following :–

Hospital Student Nurses	150
Hospital Administration Student	1
Local Government Student	1
Social Administration Student	1
D.P.H. Student	1
Health Visitor Students from other local authorities	3
Overseas visitors	3
Community Nursing Course Students	9
Nursery Nurse Students	30
Technical College Students	12

STUDENT HEALTH VISITORS

Five student health visitors completed their training in July and were successful in examinations; five commenced training in September but one had to withdraw from the course for personal reasons; one male commenced health visiting officer training in Aberdeen.

IN-SERVICE TRAINING AND REFRESHER COURSES

A two-week in-service training was arranged for all new clinic nurses and nursing auxiliaries appointed during the year.

Two courses on "Child Development" given by Dr. R. I. Mackay, Consultant Paediatrician, were attended by 26 health visitors.

A study day was arranged in July to discuss "Work Patterns of the Future" and was attended by health visitors, district nurses and representatives from other local authorities; 68 in all.

Four health visitors attended a course "Social Studies for Health Visitors" arranged by the Extra Mural Department, Manchester University, on one half day a week for a period of twelve weeks.

Films of interest were shown throughout the year and individual talks on various topics, e.g. "Changes in Supplementary Benefits", "Clearance Areas", were arranged and attended by appropiate staff.

It should also be recorded that a number of health visitors, in their own time and at their own expense, attended lectures and courses designed to increase professional knowledge and these included subjects such as mental health and the care of children from inadequate homes. The liaison health visitor concerned with diabetic after-care attended the Annual Diabetic Conference.

HEALTH EDUCATION

(a) Toddlers' Clubs

These clubs which were formed last year continued to function at fortnightly intervals and we are grateful for the voluntary services of members of the League of Jewish Women who assist by caring for the children whilst the mothers are discussing problems of common interest or watching educational films. Because of the great demands on staff time, the voluntary help which can be afforded by such organisations proves invaluable and makes it possible to continue discussions for a small group of mothers which would be uneconomic in staff time, however great the need, if another member of the staff had to be delegated to assist.

(b) Hope Hospital

162 discussions were held with mothers on the post-natal wards of the hospital embracing many aspects of child care and home safety.

Apart from the value to the mother at a time when she is very receptive to advice, the health visitors too have benefited from this arrangement, in that mothers who have attended these discussions are made aware of the domiciliary visiting which follows discharge from hospital and are prepared to bring out their problems straight away instead of waiting to get to know the health visitor. The fact that the area health visitor is not necessarily the one known to the mother during her stay in hospital seems unimportant; she is accepted quickly as the colleague of the health visitor met in hospital.

(c) Salford House

Attempts to interest the men in some aspects of health education were abortive. The interruption of a long established pattern of playing games, reading and smoking was not well received and it was decided that staff time could be more usefully employed in other ways.

(c) MOTHERS' CLUBS

Evening meetings were held regularly at fortnightly intervals at three Mothers' Clubs, the average attendance being 25. These clubs fill a real social need and also provide the opportunity for some indirect health education. Two mothers with severe physical handicaps attend a club and many others experiencing mental stress have been encouraged to attend.

Talks were given to outside organisations on request and assistance was given in an in-service training programme for home helps.

SCREENING TESTS OF HEARING

The results of tests undertaken during the year were as follows :–

Total number of children tested	1,179
Number passed at first test	1,018
Number passed after re-testing	134
Number failed and referred to University Audiology Clinic	27

Of those referred to the University the results were as follows :–

Referred for treatment by E.N.T. Consultant	6
Referred for further investigation	2
Found to be profoundly deaf	1
Lack of auditory response due to linguistic retardation	1
Did not attend for investigation	2
Found to be satisfactory	3
Awaiting appointment	12

STATISTICS

A statistical summary of visits paid and clinics attended by all members of the staff of the Health Visiting Section is given below :–

Health Visitors and Clinic Nurses

Type of Visit	Access	No Access
Visits to children 1 – 5 years	30,183	
Visits to aged persons	10,358	
Visits to tuberculosis patients	675	
Visits to expectant mothers	394	
Hospital follow-up visits	315	
Mental Health visits	139	
Immunisation visits	4,338	
Visits to special groups	1,832	
Miscellaneous	7,273	
	55,507	11,486
GRAND TOTAL	66,993	

Clinic Sessions

Health Visitors and Clinic Nurses	2,553

Nursing Auxiliaries (a) Visits

Type of Visit	Access	No Access
Bathing – children	1	
Bathing – aged infirm	2,472	
Foot Hygiene – aged infirm	4,845	
Miscellaneous – aged infirm	1,972	
Miscellaneous – general	99	
		341
	9,389	341
GRAND TOTAL	9,730	

Nursing Auxiliaries (b) Clinic Sessions

Type of Clinic		Sessions
Screening tests of hearing with Health Visitor	equivalent of	109
Child Welfare with Health Visitor	,,	440
Day Training Centre with Specialist Health Visitor	,,	119
School Minor Ailments with Clinic Nurse	,,	177
Chiropody – children – assisting Chiropodist	,,	340
Chiropody – elderly – assisting Chiropodist	,,	343
Special bathings – school children	,,	77
School medical examinations with doctor	,,	115
Cleansing	,,	145
Special Clinics	,,	64
Health Check-up with Health Visitor	,,	140
Syringe Service	,,	579
Miscellaneous		133
TOTAL		2,781

Nursing Auxiliaries (c) School Sessions

Type of Work		Sessions
Assisting at Health Surveys with Health Visitor	equivalent of	248
Vision testing	,,	143
Hygiene Inspections	,,	455
Hygiene Re-inspections	,,	244
School medical inspections with doctor	,,	68
Assisting doctor or Clinic Nurse with immunisations in school	,,	87
Miscellaneous	,,	71
TOTAL		1,316

DAY NURSERIES

1966 was the first full year in which the City had only 3 day nurseries functioning, and this reduced the number of available places from 235 to 140.

It was not possible to meet the demands for admission which numbered 454, even though throughout the year the number of children on the register was kept higher than the actual places available to offset the wastage due to absenteeism.

The average daily attendance was 109.92 per 140 places, i.e. 78.5%. The lowest daily attendance was 85 – 60.7% during Christmas week and the highest 130 – 92.7% during the Summer.

In view of the waiting lists at each nursery, absenteeism causes some concern, and when a child is absent from the nursery for any length of time and no reason is forthcoming, the parent is advised by letter that the child's name will be removed from the register unless a satisfactory explanation is given. Much of the absenteeism can be accounted for by illness of the children but 37 children's names were withdrawn because no satisfactory explanation was given. 959 odd days of absenteeism were recorded.

Priority was given for admission throughout the year to the special categories previously established, and only on rare occasions was it possible to offer places to those in the financial category i.e. both parents working.

Applications are classified:

Illness	A1 Illness of father A2 Illness of mother A3 Confinement	Priority Groups
Social	B1 Acute social problem B2 Handicapped child B3 Behaviour problem	Priority Groups
One parent	C1 Unmarried mother C2 Widowed C3 Separated C4 Divorced	Priority Groups
	D Mother in essential employment	
	E Financial reason	

AVERAGE DAILY ATTENDANCE

This fluctuated throughout the year, low attendance often occurring during holiday periods.

Average daily attendance	Percentage of possible 140	No. of weeks involved
85 – 89	60.7% – 64%	4 weeks including Christmas, New year and Whit week
91 – 99	65% – 70.7%	7weeks including August 1st
100 – 109	71.4% – 77.8%	16 weeks
110 – 120	78.5% – 85.7%	15 weeks
121 – 130	86.4% – 92.8%	10 weeks

STATE OF PREMISES

Two of the existing buildings were built as a war-time need and are now in need of either replacement or considerable renovation. Apart from the fact that these Nurseries were built when materials for buildings were restricted, many of the fixtures and fittings are quite out-dated and not acceptable by modern standards. If these Nurseries are not to be replaced by new buildings, there is a great need for new heating arrangements and for floor tiles throughout both Nurseries to cover old wooden block floors. Where possible, the nursery furniture has been given modern hygienic surfaces and re-painting has taken place.

STAFFING

Mrs. F. Tomlinson, matron of Howard Street Nursery retired because of ill-health in December after 22 years' valued service with the Health Department. Mrs. E. Dickenson, Deputy Matron, was promoted to Matron.

HOME NURSING SERVICE

Our home nursing service is available to all who need nursing care in their own homes. The staff consists of Queen's nurses, State enrolled nurses and nursing auxiliaries who work in groups. These groups are centred in the clinics in the City, at Regent Road, Langworthy Road, Murray Street, Kersal Centre and in the new Trinity Centre. With this decentralisation the nurse has less travelling so can give more time to her patients. With the greater number of disposable articles for her use she can give greater care to the relatives in their endeavours to give comprehensive care in the home. The relative who has charge of the patient needs the support and expert advice of the nurse who has had special training to work in the home, most especially when the illness is of long duration or intense as during terminal illness.

The District Nurse has had support from all members of the Health Department including Physiotherapy, Chiropody, Home Help, Public Health Inspectors, Health Visitors and Mental Health Service during the past year. Many discussions and consultations have taken place which have widened the knowledge of each other's sphere of work in the City, improved relationships which must lead to better care for all our patients.

There has been some replacement of staff, and the students have been successful in passing their examinations and gaining the Certificate of the Queen's Institute of District Nursing and the Certificate of the Ministry of Health.

Students

We have had many observers and students during the year who have been impressed by the standard of care and attention given to all our patients.

The observers have come from Queen's Institute of District Nursing, London School of Hygiene and Tropical Medicine; Social Administration, Glasgow.

Home Physiotherapy

During the past year we have benefited by the help we have received from the Physiotherapy Section. We have referred patients and the District Nurse has visited with the Physiotherapist and discussed and decided on a course of action to the greatest advantage of the patient. Many of these patients have suffered from hemiplegia, fractures and have received treatment treatment in hospital but on return to home have found the journey back to hospital tiring and exhausting. This service, which is unique, is fulfilling a need and is also supplementing the good work carried out in the hospital towards the eventual rehabilitation of the patient. Though the recovery rate may not be 100%, the help to the relatives in the carrying out of this service cannot be measured, as they feel that something is being done to help and restore the ailing member of the family. In this way the family is held together and other services are freed to help patients in need of special care.

No. of patients referred	44
No. of patients still under supervision	32
No. of patients taken off treatment	12

LOAN EQUIPMENT

Our range of equipment on loan to those in need remains stable and the articles most in use are rubber sheets, bed pans, back rests and urinals. There is also a demand, which fluctuates, for wheel chairs, commodes, beds and mattresses and the smaller articles such as bed cradles, sheets, pillow-cases and draw-sheets.

We have 3 hoists in permanent use: these are invaluable as the relatives are able to cope with the difficulties of moving patients who are incapable of moving out of bed under their own steam, from room to room, keeping them happily within the family group.

Disposable incontinent pads have a fairly steady usage rate which does not appear to fluctuate over the years. New materials to help to make this problem easier to manage in the home have been presented to us by the manufacturers of these products and, though some are excellent for hospital use, have little use in the home especially when the pad has to be disposed of in this City of smokeless zones – paper can be burned, polythene is difficult to burn, and thick cellulose wadding cannot be put in the dust-bin if heavily soiled. We are grateful to the Cleansing Department for all their help in this situation.

Disposable equipment for the use of the nurse is becoming more sophisticated and packaging is brighter and more attractive, both to the nurse, the patient, and the onlooker. Where syringes are involved in injection technique the syringe must be seen to be rendered unfit for further use and disposed of either by wrapping in newspaper and putting in the dust-bin or incinerator or by the nurse taking the syringe away with her for disposable action at the centre.

CYTOLOGY

This important test which is available to all the women in the City in the clinics has now been extended to those women who have difficulty in attending because of family commitments. We visited the City of Derby to look at the training and service they provided.

Our service has been mainly for those women at greatest risk and those who have failed, after requesting the test, to attend.

No. of women requesting test	148
No. of visits made	236
No. of tests taken (smear)	36
No. of requests for home visit	7
No. of failures to take test	112

Reasons for failures

Removal from area	47
No access to house	30
Business too demanding	16
Family problems	33
Too anxious to take test	12
Too frightened to know answer even if negative	10
Wish to attend clinic	17
Had not made request	4
Women who were attending hospital	10

Before the Health Check-up campaign began some District Nurses were instructed in the technique of taking the cervical smear test and during the Campaign carried out 250 tests.

From the table it is obvious that cytology is expensive of the time of the district nurse as in 236 visits only 36 women consented to have this test carried out. The 112 women who refused had one or more reasons for refusing amounting to 179 reasons in all. Of these 47 had removed from the area as some houses had been demolished and these were difficult to trace.

All the District Nurses have the choice as to whether or not they wish to receive instruction in taking the smear and those whose areas have a greater number of women at risk are dismayed by the apathetic attitude of the women and also by the great depth of ignorance on hygiene and preventive measures offered to them by the City.

LAUNDRY SERVICE

There is a small group of patients who, as younger relatives moved to the "overspill" areas, are now finding it difficult to keep essential bed linen clean. With the purchase of sheets, draw-sheets, pillow-cases, we are able to lend these goods and keep patients in comfort at home. The laundry is collected and delivered twice per week and is, by its regularity, not putting too great a strain on the resources of the people most in need who are, on the whole, elderly, not too fit, and handicapped in some way.

STATISTICS

We have had much the same pattern of referral during the past year but the pattern of work has changed and rehabilitation for all patients in our care has gained in importance and health teaching during our visits has been more emphasised.

Number of patients on books at end of year	617
Number of patients taken off books	1,843
Number of new patients	1,815
,, ,, ,, recovered	920
,, ,, ,, transferred to hospital	445
,, ,, ,, died	221
,, ,, ,, transferred from area	38
,, ,, ,, transferred for other reasons	219
Total number of patients	2,460

Number of Visits	60,680
Number of surgery visits	2,216
Number of visits for cytology	236
Total Visits	63,132

Referral of new patients	1,815
General Practitioner	1,381
Hospitals	308
Health Visitors	51
Midwives	3
Personal applications	16
Others	56

The number of children under 4 has been 60, who have had 483 visits, which is less than 1965 when 80 children had 581 visits.

Those in the 5 – 14 years group have had 347 visits to 46 patients (in 1965 61 children received 280 visits).

There appears to be a greater need of care for the 40 to 64 years group; these patients having received 17,128 visits.

Of the 678 patients in this group suffering from :–

Cancer	71	needed	1,664	visits
Heart disease	59	,,	2,278	,,
Stroke disease	48	,,	1,852	,,
Respiratory disease	37	,,	490	,,
Anaemia	86	,,	1,566	,,
Nervous diseases	25	,,	747	,,
Mental Illness	8	,,	97	,,
Diabetes	23	,,	3,060	,,
Other medical	180	,,	2,206	,,
Surgical	141	,,	2,178	,,

In the 65 to 74 years group we have had 579 patients needing 16,645 visits and the 795 over 70's have had 21,424 visits.

In the 15 – 39 years group 302 patients had 4,653 visits. The working group aged between 15 and 39 years suffering from :–

Infectious diseases	31	had	491	visits
Cancer	5	,,	35	,,
Heart Disease	2	,,	12	,,
Anaemia	17	,,	394	,,
Nervous diseases	11	,,	1,095	,,
Mental disorders	6	,,	96	,,
Diabetes	5	,,	49	,,
Anaemia of pregnancy	88	,,	701	,,
Complications of pregnancy	10	,,	60	,,
Other medical	59	,,	854	,,
Surgical	68	,,	866	,,

EVENING VISITING

Our late evening service continues to fulfil a need both to relatives and patients, who require drugs, comfort, re-assurance and nursing care before being settled for the night. This service is carried out between the hours of 8.00 p.m. and 10.00 p.m.

No. of patients visited	115
No. taken off books	107
Died	39
Transferred to hospital	31
Transferred for other reasons	37
Number of Visits	2,162
Average visits per month	180
Average visits per evening	6

MARIE CURIE MEMORIAL FOUNDATION FUND

This voluntary fund continues to be available to help those patients suffering from Cancer who need those extras which enable the patient and the family to cope with the additional expense and difficulties which occur when sickness of a member of the family is the main concern of the group. We have helped with extra nourishment, Complan, Bovril, payment of laundry bills and lending blankets, sheets, pillows, pillow-cases when need arises.

CHIROPODY SERVICE

During the year, the chiropody service for the aged, handicapped and expectant mothers satisfied the many demands made upon it.

At 31st December there were 2,397 patients receiving treatment and 575 new patients had been accepted for treatment during 1966. This number of new patients was made up of 365 walking cases, 70 patients who would require the sitting car to take them to the clinic and 140 patients who would have to receive treatment in their own homes. In all, 7,550 chiropody treatments were carried out during the year.

Since the inauguration of the service, there has been a steady flow of new patients requesting foot treatment and if, during the course of one particular year, there appears to have been a reduction in numbers experience shows that during the following year referrals have increased.

The following figures show the number of new patients accepted for chiropody treatment during each of the last six years.

1961	1962	1963	1964	1965	1966
663	1,059	884	308	494	575

There has been a recognisable increase in the number of patients on the domiciliary chiropody list during 1966. The following figures show the number of patients having home treatment during the past seven years, each domiciliary patient averaging approximately four visits per year.

1960	1961	1962	1963	1964	1965	1966
184	257	367	432	404	388	482

The housebound patient presents a special problem in terms of the time and expense involved in treatment but, as noted in previous reports, the chiropodists manage, in many instances, so to improve the condition of the feet of these people that some become ambulant and are able to leave the confines of the house.

Apart from any other factor, it can do nothing but good for the previously housebound patient who is now able to go out, even if only by sitting car, to leave his house for treatment at the clinic. This "outing" appears to cheer the patient up to a surprising extent and the fact that the patient has undertaken the journey successfully and, at the clinic, met other people with similar problems, must prove of therapeutic value.

Unlike the foot health service for school children, the discharge rate in the chiropody service for the elderly is very low. Even when the original condition of which the patient first complained has been successfully treated, we must then keep the feet of the patient under surveillance to prevent the condition recurring and also to nip in the bud any abnormality which may arise in the feet of the aged.

One of the problems still apparent is that the elderly person has often to make do with footwear which has long since worn out and one even occasionally hears of a pensioner who buys a pair of unredeemed shoes from a shoe repairer for the few shillings that the repair may have cost because this amount is all that the purchaser can afford out of his pension. Other elderly people are noticed to have shoes of the wrong shape and size with the shoe creases in the wrong position for the normal articulation of the wearer's feet. These shoes have sometimes been bought at a jumble sale or have been donated to the pensioner by a well-meaning relative or friend.

This is a very sad state of affairs to meet with in this age of affluence, but when one realises that a pair of shoes of the fitting that many old people need can cost a week's pension, one can easily understand the trepidation with which the pensioner considers the purchase of a pair of new shoes. Perhaps another reason for the habitual use of cast–off shoes could be that what was necessity in the patient's youth, now has become a habit in old age.

It has been said that "there are no bad feet without bad shoes". This is only partly true, but with the onset of old age the impairment of repair and healing processes must not be ignored, and for this reason at least a well-fitting shoe is as necessary at this time as at any other time throughout life. When shoes have outlived their usefulness, a heaping up of the insole occurs just distal to the articulation of the metatarso–phalangeal joints, which, in an elderly person with suspect circulation and impoverished skin, lends itself to severe callosity formation and the ensuing subluxation at the metatarso–phalangeal joints gives rise to severe metatarsalgia. This defect of old footwear is a common reason for the frequency with which this painful and crippling condition is found in the aged.

The diabetic, neuropathic patient is very much at risk with bad footwear and it is hardly of lasting value to treat the lesion without also obviating the source of aggravation, namely, the ill–fitting shoe.

A breakdown of the percentage of patients attending each clinic was carried out and the following figures were recorded :–

Langworthy Road Clinic

	Invited	Attended	Emergency treatments	
p.m. Monday	727	615 (84.4%) +	9	
p.m. Tuesday	758	618 (81.5%) +	9	
p.m. Wednesday	302	269 (89%) +	19	Sitting car session
p.m. Thursday	794	643 (80.9%) +	18	
p.m. Friday	759	619 (81.5%) +	18	
	3,340	2,764 +	73	= 2,837

Average attendance at Langworthy Clinic 82.75%

Regent Road Clinic

	Invited	Attended		Emergency treatments		
Evg. Monday	300	261 (87%)	+	20		
a.m. Tuesday	408	308 (75.6%)	+	6		
a.m. Thursday	805	657 (81.6%)	+	8		
	1,513	1,226	+	34	=	1,260

Average attendance at Regent Road Clinic 81%

Murray Street Clinic

a.m. Monday	688	553 (80.3%)	+	9		
a.m. Tuesday	364	296 (81.3%)	+	11		
	1,052	849		20	=	869

Average attendance at Murray Street Clinic 80.8%

Kersal Centre

a.m. Wednesday	359	303 (84.3%)	+	23		
Evg. Wednesday	312	278 (89%)	+	16	Sitting car session	
a.m. Friday	350	298 (85%)	+	20		
	1,021	879	+	59	=	938

Average attendance at Kersal Centre 86%

During the Health Check-up at the Crescent, nearly 1,000 people asked to have their feet examined by the chiropodist. Unfortunately, because of clinical commitments, the chiropodist could not be present at every health check-up period, but when absent, those citizens desiring a foot examination were informed on the next occasion on which the chiropodist could be consulted. It was most gratifying to see the high number of people who took the trouble to return for an examination of their feet. This gave the chiropodist an opportunity to discuss with foot sufferers their problems and give advice as necessary.

FOOT HEALTH SURVEY STATISTICS

Number of people examined	Males	475	
	Females	461	Total 936
Number of people with foot defects	Males	304	
	Females	337	Total 641
Number of people complaining of foot trouble	Males	188	
	Females	124	Total 312
Number of people experiencing foot troubles who are in receipt of professional treatment	Males	45	
	Females	102	Total 147

Number of people experiencing foot troubles who are treating themselves	Males	38	
	Females	34	Total 72

It was found necessary for the chiropodist to refer 55 patients to their family doctors because of the suspicion that the foot trouble was secondary to a disturbance in the patient's general health.

The following list is an indication of the main foot troubles experienced by people of working age who attended the foot health check-up.

+ Defects of the skin (corns, warts, fissures etc.)

Males	179	
Females	201	Total 380

Nail defects (Ram's horn nails, ingrown toenails,) (Mycotic nail infections, paronychia etc.)

Males	72	
Females	87	Total 159

Orthopaedic defects (Hallux Valgus, Metatarsalgia) (Hammer toes, Pronoted feet etc.)

Males	164	
Females	263	Total 427

* Interdigital conditions (skin infections, hyperhidrosis etc.)

Males	89	
Females	15	Total 104

*Many of the men requiring advice exhibited a very macerated skin due to wearing occlusive protective footwear as part of their work uniform. Instructions were given to these men on how to keep the skin of their feet in a healthy condition despite their footwear.

+ Some women, who habitually wore sling-back shoes during the summer months, suffered an inspissate condition of the skin around the heels and advice was given regarding suitable epidermal lubricants for home use.

Many people availing themselves of the Foot Health Check benefited by advice on where to seek treatment and advice regarding the prevention of foot trouble in later years, especially where the chiropodist noticed an incipient condition.

This foot health check (probably the first of its kind in the country) proved to be of tremendous benefit to those who availed themselves of it.

STATISTICAL SUMMARY OF CLINICAL AND DOMICILIARY CHIROPODY FOR THE AGED AND HANDICAPPED DURING 1966

Total Number of Treatments Given				7,550
Treated at Clinics	16.4%	Male	970	5,904
	83.5%	Female	4,934	

Treated at Home	16.4%	Male	271		
	83.5%	Female	1,375		1,646
					7,550

Langworthy Road Clinic

Sitting Car Cases	Male	56		
	Female	447	503	
Walking Cases	Male	353		
	Female	1,981	2,334	2,837

Regent Road Clinic

Walking Cases	Male	250	
	Female	1,010	1,260

Murray Street Clinic

Walking Cases	Male	140	
	Female	729	869

Kersal Centre

Sitting Car Cases	Male	42		
	Female	230	272	
Walking Cases	Male	131		
	Female	535	666	938
			Clinic Total	5,904
			Domiciliary	1,646
			Grand Total	7,550

Total Number of Patients on Register at 31st December 1966 2,397

Number of Walking Cases	66%	1,576
Number of Sitting Car Cases	14%	339
Number of Domiciliary Cases	20%	482
		2,397

Total Number of New Patients referred during 1966 575

Total Number of Clinic Sessions Held in 1966 932

Sessions at Langworthy Clinic	Day	440	440
Sessions at Regent Road Clinic	Evening	48	
	Day	152	200

Sessions at Murray Street Clinic	Day	137	137
Sessions at Kersal Centre	Evening	51	
	Day	104	155
			932

Total Number of Patients Invited to Clinics during 1966 6,926

Total Number of Patients who attended Clinics during 1966 5,904

	Invited	Attended	Defaulted
Langworthy Clinic	3,340	2,764	576
Regent Road Clinic	1,513	1,226	287
Murray Street Clinic	1,052	849	203
Kersal Centre	1,021	879	142
	6,926	5,718	1,208
		(82.5%)	(17.4%) Attended 5,718

Number of Additional Cases

Dressings	88
Observation	—
Emergency	98
	186

Attended 186

5,904

Average Number of Treatments per Session

5,904 Treated

932 Sessions = 6.3 patients per chiropodist per session.

HOME HELP SERVICE

During the past year the Home Help Service has continued its efforts to meet the domestic needs of the residents of Salford, who, for reasons of maternity, sickness, convalescence, old age and infirmity, or an emergency in the household due to sickness are not able to maintain a reasonable standard of cleanliness in the home.

The Home Help is often frustrated by lack of equipment in many homes and although she is renowned for her resourcefulness, ingenuity and ability to improvise, a large amount of time is being badly used. Some householders are most reluctant to purchase even the basic essential cleaning materials to enable the Home Help to carry out her duties in a satisfactory manner.

The changing pattern of community life means that very often people live alone with neither relatives nor friends to give comfort and practical help. Some are severely handicapped and house-bound but with the assistance of a Home Help, manage to live a comfortable, well-ordered and dignified life. The Home Help is often the only regular visitor and contact with the world outside their front door. Quite a number of the recipients of the service are elderly widowers who have previously relied on their late wives for the smooth running of the household and, when left alone, are quite unable to cope with even simple tasks although they may be remarkably fit, and unless help is provided conditions rapidly deteriorate. The Home Help is able to assist by teaching how to make beds, do the daily chores, simple cooking and sensible shopping. It is very heart-warming when the organiser visits to be shown with great pride the new skills the Home Help has taught. The new-found interest in keeping the home nice and clean often goes some way to compensating for the loss of wife and job – itself a great problem to the specialist social workers.

The basic duties of the Home Help have remained the same – washing, shopping, cooking, cleaning and caring for any children in the household where she is working. In addition to this, we have carried out a limited "night sitter" service, daily visits to light fires, bring in coal, assist with dressing, put on surgical boots etc., and to cook mid-day meals for bedfast and handicapped patients who find that the "Meals on Wheels" service is not suitable, often because of special diets and particular needs.

Mrs. M. E. Hughes took up the appointment of Home Help Organiser in November 1966. The visiting and office staff of the department is now up to establishment. The clerks have a constant battle to keep up to date with the vast amount of clerical work necessary for the efficient organisation and control of the service. Applications from ladies wishing to be considered for employment as Home Helps continue at a steady rate. The percentage of terminations of employment 33% is rather high, but this is usual in the Home Help Service and not peculiar to Salford. Applicants are very carefully selected and many are found unsuitable for our particular requirements as we demand a high standard of domestic knowledge as well as of integrity and kindness and also the ability to work conscientiously without constant direct supervision.

Training of Home Helps continues in importance not only from the practical side, but in so much as it inspires pride in the quality of work and stimulates greater interest and understanding of the wider aspects of community care.

Details of the number of cases helped and referred for help during the year are given below :–

Cases helped over 65 years of age	1,818
Maternity cases	59
Total number of cases helped	2,165
Average number of cases helped each week	1,224
Average number of Home Helps employed	274

Sources of referrals :

Health Visitors	283
Medical Social Workers	104
Self	103
Relatives	103
General Practitioners	76
Civic Welfare	63
Home Nursing	55
Ministry of Social Security	29
Midwives	16
Children & School Welfare	8
Councillors	7
Mental Health	6
Housing	5
Home Helps	5
Social Workers	3
Public Health Inspectors	2
Cripples' Help Society	2
TOTAL	870

The Home Help Organiser is exploring ways in which the service can best be utilised to complement the specialist work of all the statutory Health Department services, General Practitioners, Hospitals and Welfare Services. Many of the applications for help are received from these sources as stated above and, where necessary, are given priority help if circumstances are regarded as urgent. Emergencies do occur and help is provided with a minimum of delay.

The future administration and form of the Home Help Service will, perhaps, be resolved by the findings of the many important committees and research projects currently investigating the service. It would be a great pity if all the proven experience of the Home Help Service as part of the Medical Officer of Health's team were to be changed. Even greater co-operation with all the domiciliary services can only result in more and better care and attention for the needy residents of Salford.

MENTAL HEALTH SERVICE

INTRODUCTION

The year 1966 has furthered the processes of integration discussed last year, and we report developments in a number of fields. Co-operation with the hospital services was further enhanced towards the end of the year, by the appointment of new staff, and in this report we describe some of the methods and mechanisms evolved. Both psychiatric consultants now being involved with mental hospital, both general hospitals and the local authority, the clinical work is even better integrated into the service as a whole, the junior hospital psychiatric staff also having been drawn in to a fair degree.

In two short papers we describe and discuss our experience in expanding and integrating our work in the context of general practice, and in the field of child and family guidance. A further paper discusses more broadly some of the ways in which adolescents call upon our services, and some of the implications for the future.

We report some success in psychiatric rehabilitation in the hostels, but in other ways we are conscious of present inadequacies in the service and difficulties which threaten much of what has been built up over the years. The most important of these, centres round our current inability to attract social work staff to replace those leaving for further training or higher posts. We are hoping to establish senior posts in the department to form a stable nucleus of professional workers, and to allow us to extend our commitment to students, trainees and graduate staff for in-service training, We must continue to attract workers in this highly competitive field, if the work is not to suffer.

We also describe the disquieting situation regarding the pre-school mentally handicapped child, though we can hope that the new building now rising to replace our junior centres will eventually ease matters. Our hopes of obtaining flatlets for the mentally ill and of expanding our day centre facilities have again been disappointed and plans have been indefinitely postponed. There are problems other than finance, but this now dominates most situations within the social services, nationally and locally. But we cannot have effective and comprehensive social services unless we are willing to pay for them. At the same time we must acknowledge the importance of efficient operation of services, which can easily be left behind by new situations, using out of date methods, holding to obsolete priorities, even over-staffed. The proper ordering of priorities in the service as a whole becomes more difficult but more important when finances are restricted.

Nevertheless we are able to report some advances, and valuable work continued from the past. We discuss day centre work in conjunction with the hospital, but three other groups including a psycho-geriatric group continue to meet and benefit from the care they receive. Two social clubs we mention, but the subnormal club also continues its good work. We have continued too, to resolve the recurrent transport problems associated with our day centres, helped during 1966 by a new Sitting-Ambulance/Van and the 'Variety Club' Coach received at the end of 1965.

Research

The department's research interest has for eight years now focussed upon the Salford Psychiatric Register reported on last by Dr. M. W. Susser in the Annual Report for 1964. This project continues with the co-operation of the hospitals and in conjunction with Manchester University Department of Social and Preventive Medicine. In the absence of Dr. Susser, new plans are being made for further analysis and any necessary revisions in the collection of data. Three lesser projects are commented upon briefly in this report – an evaluation of 'health teams', a survey of emergency calls, and a follow-up of subnormal adults which continues the work on the epidemiology of subnormality supported by a grant from the National Society for Mentally Handicapped Children.

A further project not directly involving the Mental Health Section, but of prime importance in preventive mental health work, involves Salford and the adjacent division of Lancashire County and is centred upon the Assessment Unit of the Royal Manchester Children's Hospital. Amino-acid screening for disorders leading to brain damage, including phenylketonuria, has been undertaken for all new-born infants, and health visitors collecting the necessary blood samples have achieved a 96% coverage. Laboratory investigation including paper chromotography is used not only to exclude known disorders, but to establish haematological norms.

ORGANISATION OF MENTAL HEALTH SOCIAL WORK

Last year we reported organisational changes in our social work, which have proved beneficial. The most important has been the formal supervision offered to graduate staff by professional social workers. This has remained a vital individualisation of our In-Service training programme, alongside the weekly case conference and seminar, which programme has also met the needs of our many students. Requests for us to take students increase, but, although they contribute valuable work to the department, professional resources for adequate supervision are limited. We have also accepted the responsibility of training social workers from scratch, and during 1966 two trainee posts were established and filled, with a commitment to provide preliminary training and experience in mental health social work, and later sponsorship for formal professional training. At the same time these additional people add variety and flexibility to our social work team. Two graduates left us during the year but were replaced by professional workers who have greatly strengthened the department.

We welcome the belated national recognition, with the new N.J.C. Salary Scale, that a mental welfare officer is not fully qualified without professional social work training. The responsibility remains with Local Authorities to employ qualified staff where social work is necessary. Some have already attracted qualified workers in large numbers – one London Borough employs sixteen psychiatric social workers – and thus are able more rapidly to develop lagging community services. The London area, in itself, attracts many young people, but when they are further tempted by salaries far in excess of those elsewhere – even acknowledging the higher cost of living – and posts designated 'senior', competitors in the industrial North have little chance. We have until recently been able to rely upon the attraction of work in an integrated and comprehensive service within a professional team, and to some

extent upon Salford's reputation, but this cannot last long. Many other areas can now offer the same attractions, plus higher salaries, senior gradings, house and car loans and pleasanter surroundings. Unless we continue to retain and recruit social workers our service will soon founder and years of painstaking development be lost. We are not alone in this; it is common to all Northern Authorities though some may not yet realise their plight. London looks like monopolising professional workers – even one Welfare Department is employing five psychiatric social workers – unless the drift is reversed. A national perspective is essential and it may well be time for the Ministry, Local Authorities and the Profession to accept this common responsibility. We will take what measures we can.

Meanwhile, following many London Boroughs we hope soon to abandon the anomalous distinction between Mental Welfare Officer and Psychiatric Social Worker when both are doing similar work, in favour of the generic term Mental Health Social Worker.

Emergency Calls

Last year we discussed the burden upon social workers of providing twenty-four hour cover for psychiatric emergencies, in addition to evening visiting and involvement in the Clubs. We, therefore, determined to survey the extent and nature of emergency referrals, a questionnaire being completed by the duty officer on each call for help outside office hours. We hoped to discover the nature of the problem as seen by the social worker, the service requested by the referrer, the service ultimately provided, and the degree to which the patient had contact with other services.

All mental welfare officers undertaking 'On-Call' duties agreed to co-operate for twelve months: the analysis is not yet completed, but we can demonstrate the demand. Seven workers participated, four for only part of the year, but contrary to our intention, three, recorded only visits, ignoring calls handled by telephone. The other four workers recorded 127 calls, 80 demanding a visit, 47 handled by telephone. Since visits by the three amounted to 58, their estimated telephone activity is 34 cases. There were therefore 219 calls out of office hours during 1966, an average of four a week. Three out of five, 138 in the year, required an excursion, on average, of two hours.

CO-ORDINATION WITH THE HOSPITAL SERVICES

We continue to fight against the natural deficiencies of the tripartite National Health Service. There can be little doubt that progressively unified mental health services have outgrown the administrative structure, and essential communications must be worked at diligently and persistently if the service is not to disintegrate into its constitutive parts. Many developments must be seen in this light.

Joint-User Arrangements

Following the joint appointment of a psychiatric social worker to serve both psychiatric hospital unit and community, a similar link was established during 1966 with the general hospital. Such a worker is able, by virtue of being an 'insider' to each organisation, to facilitate communication and mitigate aggressive corporo-centric attitudes which tend to develop in multi-

partite structures. They cannot do this alone, and joint user arrangements offer no panacea to sick organisations, where departmental rivalries are prominent. From our own experience, however, we are confident of their value if both parties share the goals of co-ordinated services and key personnel in both are committed to working to this end. If this is not so, the joint appointment itself may become the focus of dissatisfaction and only serve to accentuate the divisions.

Any social worker taking up such an appointment is likely to face rôle definition difficulties, with nursing staff at one end and mental welfare officers at the other. Working in two places at once demands considerable discipline if much time is not to be wasted, and tolerance towards institutions whose competing demands could use half a dozen workers. At the same time, staff in hospital and Local Authority must recognise the discomforts of a joint appointment and the special stresses involved. Both workers in Salford derive most of their cases from the hospital, but most of these would be referred to the Mental Health Department anyway, and when fully staffed we may be able to develop still further, the link that allows relationships with clients to be established before discharge and in the context of the clinical régime.

Joint Meetings

Medical staff have also participated in joint activity increasingly throughout the year. During the earlier months hospital psychiatric registrars proved difficult to find, and to give a little assistance with some aspects of the General Hospital work, the Medical Officer for Mental Health was seconded for two sessions a week. Fortunately, soon after, two registrars were appointed and the secondment became superfluous. A lasting contact was made however, and he continued to direct the ward patient-staff meeting, previously led by the Chief Mental Welfare Officer. A new registrar at the Mental Hospital, appointed mid-year, brought the hospital medical staff up to strength and with the arrival of a new consultant, all members have established good relations with community workers and have participated whenever possible in the weekly Health Department Case Conference. The Psychiatrist's 'Ward-Round' meetings have also involved community and hospital staff, and the Mental Hospital 'Discharge Conference' is attended by appropiate social workers.

Psychiatric Day-Centre

Cleveland House Psychiatric Day Centre has been the focus of even more intimate co-operation. Throughout 1966, in-patients in Hope Hospital have been joining other ex-patients in a group under our Art Therapist, most afternoons. The therapist herself frequents the hospital at other times and has built up long standing relationships with many patients. At the time of writing she is largely concerned with younger people, adolescent or young adult, with personality problems or neurotic disorders. She closely co-operates with hospital staff, and participates in 'ward-rounds', case discussions and patient-staff meetings in the hospital.

Such an unusual arrangement is not without its problems. It fits no standard administrative patterns and our recording system has not coped with the flexibility of referrals and attendances, which has often by-passed the central machinery. Moreover, ill-defined and variable arrangements and roles have discomfited other members of hospital and local authority staffs. The hospital also serves other areas than Salford, but it would be unfortunate to have to distinguish patients on this ground, and exclude non-Salford people from the day centre and the therapist. Lancashire Division 15 have agreed in principle to contribute financially in respect of their own patients. We are willing to face these difficulties to ensure the continuation of a service we believe important, and perhaps the only hope we have of helping this particular group of young patients.

Cleveland Social Club

This Cleveland House work has been supplemented by a club evening intended mainly for young people with emotional difficulties. A new club raised important questions of staffing, membership, organisation and programme and our initial answers were modified later in the light of experience. Throughout, however, the Art Therapist, with her day centre group and her close link with the hospital, has taken a leading role, assisted by the chief mental welfare officer and another social worker.

Initially about twenty people attended, nominated by consultant psychiatrists and social workers, half of these resident in Hope Hospital. No committee of members was possible since there was little continuity of attendance and much fluctuation of numbers. Some members were active whilst in Hope, but lived too far away when discharged. The patients from the hospital varied but often formed an 'in-group', which made a cohesive club impossible. Some patients did not find the club to their taste.

On review later in the year, the club had to be judged unsuccessful, any help received by patients having been personal and individual, and largely due to the special abilities of the therapist. We made a new start. More accommodation was made available including a tea-room, and each evening was to include some planned, more formal group activity. New recruiting efforts were made and the accent was placed upon continuity of attendance, to ensure at least a nucleus of regulars without which there can be no 'club'. Since the reformation, there has been a core of about ten members in addition to hospital in-patients, and things have much improved.

It is of interest that patient participation in club organisation has proved impossible, and it was, perhaps, unrealistic to expect this from such a group. The club has brought together a number of emotionally disturbed young people, some happy to interact with others, some isolates, but all of whom value and appear to benefit from the understanding and support offered by the therapist. There is little evidence of club loyalty, but spontaneous group discussion frequently arises which promotes wider interaction. We feel our role is to provide a milieu of acceptance and freedom in which significant relationships can flourish—particularly with the therapist—and in which patients can face their own conflicts and the realities of life's demands. We have been encouraged to see quite surprising changes in attitude, and increased ability to cope with realities, in a number of young people attending the club.

Stepping Stones Club

The Club has flourished, as always, under the command of the member-committee, and under the eye of the Deputy Chief Mental Welfare Officer. The most important development during the year has been the co-operation of the mental hospital in encouraging in-patients of the Salford Unit to come to the Club on Tuesday evenings. Transport is provided, and they are able, in this way, to get to know the club, or maintain previous contact whilst in hospital.

HOSTELS

When so much has been written about the failures of hostels in psychiatric rehabilitation, it is pleasing to report a measure of success. The changes last year, introducing a graduate warden at Kersal Hostel assisted by two of our social workers, also resident, have encouraged new methods, and permitted some evaluation of hostel function. Many patients, in the course of mental illness and sometimes of institutionalisation, suffer personality impairment which impedes progress towards independence. The hostel milieu should encourage ego restitution alongside the acquisition of an increasing range of social skills. No-one not resident in the hostel can influence much the achievement of this goal, except by appointing the right sort of people as resident staff, and ensuring conditions which preclude isolation, and in which they can constantly experiment with and re-think their regime and relationships. We have attempted to provide such conditions, not least by means of a weekly conference of all hostel staff under the guidance of the chief mental welfare officer. All aspects of hostel life are considered, but each week two residents are spot-lighted, in their progress up to date and their rehabilitation programme for the future. Such concentrated and persistent review is vital to the dynamic intention of the hostel, as is the outside influence of non-residents upon hostel activity. All contacts with the community are valuable to the work of the hostel, and many have been cultivated during this past year.

Every programme varies, but all include work. For a short time this might be within the hostel, house or garden, but soon residents are expected to work elsewhere, perhaps in a day centre or the Health Department Staff Canteen. They are encouraged in the handling of a variety of social situations at work, travelling and in the hostel, and as they make progress into open employment, or attend a government rehabilitation unit. Eventually they move into a separate bed-sitter unit within the hostel, doing their own shopping and cooking, and simulating independent life. It is of interest that a number of residents have moved into lodgings in pairs, having established significant relationships within the hostel group. Ex-residents maintain their link with the hostel, returning for advice, the occasional meal and social activities for as long a period as they wish. This greatly helps both them and those still resident.

The celerity of this programme varies greatly and some errors of selection or failures of rehabilitation must be admitted. To avoid silting up with long-stay residents as in the past, we have brought the two hostels into a closer and clearer relationship. Having exhausted the resources of Kersal

House without marked improvement residents move on to the Crescent Hostel for longer term management. Joint hostel meetings give ensured co-operation and to a large extent the two hostels have become complementary.

The past year has been encouraging, but the future remains in doubt. At the time of writing the Kersal House Staff are in the process of moving on. Such mobility is inevitable in young professional people, and it is indeed preferable to most settled regimes. But how are the lessons learned and the skills developed to be passed on to their successors? And who will succeed them? There is a national shortage of able residential workers and no recognised training or qualification for psychiatric work. The Williams Report has highlighted the problems of the future, and it seems clear to us that we must in some way bring together the staffing of hostels and the training of social workers, if we are to avoid recurrent crises. We hope to experiment with young potential social workers, resident for a specified time, perhaps two years, and then sponsored for Younghusband. The experience will be invaluable for them and we will gain from their youth and enthusiasm. Perhaps all social workers should undertake residential work, as do doctors in hospital house-jobs, to be considered fully qualified, providing at the same time the sort of staff hostels need.

We have been disappointed by the abondonment of plans to convert a large house into self-contained flatlets. The unbelievable protraction of the processes of purchase, with an apparent increase in the cost of conversion, killed the scheme. Local Government machinery is cumbersome, and often cannot handle the experimental projects demanded by changeable needs.

SERVICES FOR THE SUBNORMAL

Training Centres

It is a characteristic tendency of the dispersed units of community services to become isolated, inward-looking and eventually alienated from each other and the central organisation.

Administrative problems can therefore be expected when six, small, geographically separate units serve overlapping interests with one overall purpose. For example, our two adult training centres operate independently to a degree which limits free movement of trainees from group to group, and encourages unequal allocation of contract work, and inefficient use of staff.

In the last Annual Report we discussed the conflicting goals in training centres and the primary need for social training. It is in the rigidity of the small isolated unit and the fragmental service that conflicts most readily arise between production and training: the interests of the trainee demand flexibility within a unified service. We have for some time encouraged the mental health social worker to participate in decisions affecting the placement of trainees, and more recently we have established in the centre a weekly staff meeting attended by the appropiate social worker and the Chief Mental Welfare Officer. The focus of discussion is the progress of individual trainees, but organisational problems have predominated. It has proved especially valuable in providing opportunity for younger members of staff to propose ideas and methods otherwise unheard. All adult training staff will be encouraged to attend this meeting to promote a more co-ordinated service

for subnormal adults. This is particularly needful over the next year or so, for at last a new adult training centre is in view and we must prepare for the imposed unity of a single building.

A road widening scheme caused us to abandon the Broad Street Centre, and temporary premises were found in a converted day nursery in Hulme Street. The smaller accommodation has proved adequate, largely because the more able trainees are now working in a local spinning mill. The mill's modern equipment cannot remove cotton remnants from bobbins returned by the weavers and this one manual operation resulted in a considerable bottleneck. It is however well suited to the abilities of mentally handicapped people, and a group of about eight subnormal and severely subnormal adults have settled well to regular work. Initially accompanied by centre staff, they are now satisfactorily working under the supervision of the mill management, who have been most co-operative and enthusiastic throughout. Some individuals have graduated to ordinary employment at the mill after a period with the bobbin group.

Training Centre Organiser

During the year the Education Organiser has left us for a similar post in the South of England, and we took the opportunity of re-thinking the organiser role in the light of his experience. The greatest need is for co-ordination and liaison with general oversight of training programmes and promotion of a comprehensive, balanced and unified service. This role is especially important now, as we unite the junior centres in one building and later similarly for the adult centres. To be best able to help centre staff in their work with trainees and in their working with each other, and to ensure balanced and progressive centre programmes, the organiser's primary qualification must be a thorough understanding of training centres and their work. Trained teachers not only command disproportionately short hours and high salaries for the mental health service, but are unlikely to be thus qualified. The post has therefore been changed from Education Organiser (a remedial teacher on the Burnham Scale) to Training Centre Organiser on an A.P. Scale, and requiring the N.A.M.H. Diploma for Teachers of the Mentally Handicapped.

The new Organiser will be appointed in time to take on the important work of preparing the two existing junior centres for their move into the new building. This is to be called "The Margaret Whitehead School", and will offer much wider opportunities for progressive and imaginative work than hitherto possible. The move however offers also many difficulties, and we have begun the preparatory work, with regular meetings of all Junior Centre Staff. The new building, however beautiful, will not in itself reform the service, and future work depends on the quality of the staff. We need more, and better trained teachers, but our present staff, having served us valiantly in the past, and about to face serious problems of adaptation, remain the backbone of the service.

Special Care Unit

The Special Care Unit and Infant Training Centre Group face something of a crisis situation. The demand for places continues to rise and cannot be

met. Three factors operate. Firstly, we have yet to resolve the problem discussed last year of the placement of special care children at sixteen: if they remain in the Unit, younger children are denied entry, yet there is no ready-made alternative. The Ministry have pronounced this to be the responsibility of Regional Boards, but since there is no local provision in Salford, the present hospital service does not satisfy parental demands. Neither does the Local Authority feel able to satisfy these demands under present conditions, but we are exploring the possibilities of joint enterprise with the voluntary societies. The numbers are few but the crisis is real for the families concerned. It may be that a special care group drawing young adults from an area wider than Salford could be viable under the societies' auspices and supported by the Local Authorities.

Secondly the subnormality hospital for Salford is full: even short-term care is severely restricted and long-term places are increasingly difficult to obtain. The special care alternative is therefore in greater demand. Thirdly, case finding is so efficient – largely through the hospital paediatrician – that few cases escape us in the first year of life, (see App. VIIIB). Knowing the extent of the need and the pressures on individual families, we are all the more frustrated to see the service we offer deteriorating. We were once able to fulfil our intention to offer training facilities to children of two: currently we can barely offer a place to four-year-olds, and the waiting list at 1st January, 1967, stood at 28. This places an unacceptable burden on parents and social workers. Our new accommodation promises increased space, but we will be unable to utilise this to the full unless we can recruit sufficient and suitable staff.

FOLLOW-UP OF SUBNORMAL ADULTS

In the last Annual Report we commented upon the number of subnormal adults not seen for many years, and declared our intention of following-up those who had not evidently sufficient independence to be discharged from the Register. Many reasons lie behind their neglect. The pressure of work is great, and the hard pressed social worker does not easily maintain routine calls upon subnormal people and their families, especially when they doubt the value of their visits. We know also that clients with such a prolonged interest in the department tend to get lost with staff changes, and even more so with staff vacancies. In some cases they were never found at home, and in others, visitors were unwelcome. However, all of them had real and serious problems associated with low intelligence when last seen, and we felt they warranted a special research effort to follow-up. A social worker recently retired from the department was employed for a few hours a week to do this work, and we offer here a brief report.

Referral

81 cases were investigated, 56 men and 25 women. A few had been on the Register over twenty years, but about half were clustered around a nine year period and we had not seen them for three to six years. 74 cases had been referred before the age of twenty, and only sixteen of these had been excluded from school, most of the others being referred just before or just after leaving school, for further 'supervision'. Thus most were young people who, having done badly at school, though many were not formally ascertained E.S.N., were considered to have little enough chance of settling down to a

reasonably acceptable independent working life, to warrant supervision and care from the mental health department, and registration as mentally subnormal. Usually they had been visited and helped over a number of years before being lost sight of, so that at the time of the investigation all were over twenty and most below thirty-five.

TABLE I

Referrals – 56 Men, 25 Women

Excluded from school	16	Referred < 20 years	74
Referred around School Leaving	58	Referred 20 and Over	7
			81

I.Q.

The I.Q. range using the mean in some cases of a number of assessments, was considerable – from 45 to 84. A group at the top were never intellectually subnormal and arose perhaps because of delinquency or discharge from residential school and because of their very low social status. They would not nowadays be considered candidates for the Subnormality Register, though they would be offered the services of the department. A few scored less than 50, mostly having been excluded from school, but the bulk of the cases fell between 50 and 69, that is in the generally accepted range of subnormality. 19 cases had had no formal assessment, and were usually labelled feeble-minded.

TABLE II

I.Q.

Range I.Q's. – Males 45 – 84. Females 48 – 76.

	Males	Females	Total
No Score	10	9	19
< 50	6	1	7
70 +	12	5	17
50 – 69	28	10	38
	56	25	81

Location

For each case, we aimed to collect from the notes data relevant to their situation when last seen, and by visiting, corresponding data for 1966.

Information was gathered from the subject himself or from parents or other relatives. Of the 81, no trace could be found of 9, and 5 others were known to be not in Salford. 12 further cases had moved out of Salford, but to known addresses. These figures illustrate the mobility of the Salford population over the last ten years, as housing and re-housing programmes have been carried through. In interviewing, two aspects of life in society were of particular interest to us as possible indices of independence and maturity. These were regular employment and stable marriage.

Work

Of 56 men, 25 had been working when last seen and were still working 18 were not working previously, but 7 of them now held steady jobs. 10 women of the 25 were previously in employment or housewives, and they remained so. 10 were not previously working but 4 of these had regular jobs or were housewives. In total therefore 46 of the 81 were in settled employment, and only 17 were known to be unemployed. In no case was a subject working when last seen not now doing so.

TABLE III
WORK

MEN				
Working previously	– 25	still working	25	Total Working 32
Not working previously	– 18	now working	7	Total Working 32
		still not working	11	
Unknown			13	
			56	
WOMEN				
Working or Housewife previously	– 10	still working	10	Total Working or H.W. – 14
Not working previously	– 10	now working	4	Total Working or H.W. – 14
		still not working	6	
Unknown			5	
			25	

Marriage

At the time of investigation a total of 21 subjects were known to be married, 9 men and 12 women. 2 men and 3 women of these had been married previously, and 16 therefore, including one woman in a stable co-habiting relationship had married since. One man had been married previously and was now divorced, and one woman had been married but separated during the whole of this period. 36 men and 10 women remained single throughout, and 10 men and 3 women previously single were of unknown current marital status.

TABLE IV

MARRIAGE

MEN

Previously married — 3	Still married	2	Total married 9	
	Divorced	1		
Previously single — 53	Now married	7		
	Still single	36		
	Unknown	10		
		56		

WOMEN

Previously married — 3	Still married	3	(1 Sep. throughout)	Total Married 12
	Divorced	0		
Previously single — 22	Now married	9	(1 stable cohabiting)	
	Still single	10		
	Unknown	3		
		25		

Children

We know of no children of unmarried subjects in this group. 4 children had been born illegitimate, but in every case the mother has subsequently married. Of the 21 married subjects, 16 had families: 8 men had produced 12 children and 8 women 21 children. It was evident at the time of visiting that most of these families were coping with life fairly successfully, but we have felt for some time that the children of parents who have been on the Subnormality Register are of particular interest, and we intend to do a pilot survey during 1967, covering the whole Register since 1961.

TABLE V

CHILDREN

Married men — 9, with families	—	8, producing — 12 children
Married women — 12, with families	—	8, producing — 21 children

Having investigated all our cases, we made a necessarily subjective assessment of their ability to cope – were they now exhibiting any of the problems which had originally bound them to us? 14 were not traced and 35 we judged to be still in need of our services, and were correctly retained on the Subnormality Register. 32 we felt no longer to need help from any agency such as ours, and no longer warranted classification as subnormal. They have settled down into reasonable working and family life, and have, as it were, drifted into normality over the years of maturing.

It is well known that many E.S.N. Children show increments in I.Q. score as they mature into their early twenties. Clarke and Clarke* have argued that this represents a recovery from deprivation, and Susser and Stein* have discussed the association with a demotic subculture. We have primarily concerned ourselves in this study not with intelligence test scores, or with the selections of the educational machine, but with some aspects of adaptation in society. Our cases were selected initially by the fact of their maladjustment, and we have taken regular employment, stable marriage and a subjective assessment of ability to cope as rough indices of social adjustment. A large proportion of the subjects investigated show a high degree of adjustment, in spite of the fact that the group was far from homogeneous in terms of I.Q. and educational experience. The study confirms that in terms also of function in society, subnormality (not severe subnormality) demands a dynamic concept, for those once thus categorised are now indistinguishable from the normal population.

FAMILY DOCTORS AND MENTAL HEALTH

1966 was the first full year of Family Doctor Health Teams. Consisting of family doctors, district nurse, midwife, health visitor and mental health social worker, they represent a logical extension of the system of attachment of local authority workers to general practitioners. They are intended, by fostering close relationships between the various workers, to improve communication and co-operation, so that the most appropriate help might be offered to families in need as early as possible. In this report we are concerned with the experience of the mental health social worker, but we recognise that all team members contribute toward mental health in its widest sense, and that health visitors in particular have in practice dominated the field of preventive mental health work for many years.

Since all mental health social workers have for some years been linked to particular family doctors, health teams did not require a new relationship but a much closer one. Six teams have been formed involving five social workers, but because of the particular people involved and especially because the doctors vary in the conception of their own needs and the rôles of their colleagues, each team has functioned in its own peculiar way, and not all have developed the degree of cohesiveness and group identity hoped for. They continue to evolve however, as workers come to know and understand one another better, and a year is a short time to establish new ways of working and new attitudes towards professional colleagues. We have chosen for two reasons, to discuss at length only two health teams. Firstly, these two have most nearly fulfilled our original intention, and secondly because one social worker has been involved in both of them and can therefore claim the most significant experience.

* Clarke A.D.B. and Clarke A.M. 1966, Mental Deficiency, The Changing Outlook. Methuen.

* Stein Z.A. and Susser M.W. 1960, Families of Dull Children III, Social Selections by Family Type, J. Ment. Sci. 106. 1304.

Health team 'A' was built around a group of three general practitioners particularly interested in the broader aspects of medicine and already well known to this department. In fifteen months the mental health social worker received 77 cases through the health team: health team 'B' based upon a two-doctor practice produced 25 cases in twelve months. By the end of this period a large proportion of her time was devoted to health team referrals, who constituted the bulk of her case load. A good deal less than half of them had 'formal' mental illness, being disordered to a sufficient degree to warrant clinical psychiatric intervention. Only a handful were psychotic. Cases predominating tended to have a multiplicity of problems – social, emotional and inter-personal, with a degree of anxiety or reactive depression, and perhaps personal inadequacy, that rendered them difficult to classify. Some early cases were considered inappropriate to the mental health social worker, but discussion after one visit helped gradually to define working roles within the team. Some were well known to the mental health department and other social agencies, and had appeared to exhaust them all. It has been possible, however, in the context of the family doctor health team to develop crisis intervention as a realistic way of helping and containing such cases. Crisis periods under recently developing extremes of stress featured in many families, sometimes on top of long-term stress with, for example, chronic physical disability. Some crises centred upon adolescent members of the family and others followed bereavement. In a large proportion of referrals help could not be restricted to any one person, and centred as it is upon the family doctor this can truly be considered family mental health work.

In general the mental health social worker has provided supportive visits, interpretation to clients and explanation to doctors. She has found it easier to initiate relationships with clients, and has felt more readily accepted by them, for her association with the general practitioner gives her status and respectability, encouraging their confidence, and his introducing her to them in one way or another paves the way for her first contact. In both teams the mental health social worker has been able to hold a regular "clinic" on practice premises, the doctor informing his patients individually and generally that she is available at his surgery at certain hours. This has eased the process of referral. Not only is the social worker more readily available, but the doctor knows to whom he is referring the patient and has a strong sense of her being 'his' social worker.

Many cases referred, would have come our way, if at all, only later, through formal psychiatric referral. The social worker has felt in a number of cases, that she was able to prevent breakdown by early intervention. Working closely with the family doctor allows earlier and better use of services in a truly preventive way, since he sees many psychiatric episodes in the pro-dromal phase. The doctors themselves feel that they have become more perceptive of early signs of breakdown, whilst the social worker has been helped by having access to the general practitioners' extensive knowledge of client and family.

If in most practices each community worker has related individually to the family doctor and there has as yet been little of the team about it, there will no doubt be a growing together over a longer period. The two practices under discussion who have moved some considerable way towards the desired group identity, accepted the necessity of regular team meetings to enable mutually acceptable rôle definitions to be worked out. These will

vary from team to team, and in particular different doctors, mental health social workers and health visitors will develop different ways of working together. Without regular meetings, satisfactory communication is difficult to achieve, and colleagues with different professional training must get to know each other well if they are to understand each other's roles and competance. The educative function of the group meeting for all members cannot be over-emphasised. In few cases are two workers involved concurrently though some are best handled in this way, but many families require a variety of professional services at different times, and the meeting allows full discussion. In the context of mental health work every contribution is important, but it must be remembered that meetings and case discussions can waste a lot of time if over-indulged in. In one practice also, a doctor's enthusiasm to provide all possible help to families in need has tended towards wasteful duplication of work. This however can be satisfactorily resolved within the group meeting.

The two teams under review have arranged occasional meetings with the consultant psychiatrists. The intention has been to feed in psychiatric expertise and, by illustrative case-discussion, to increase knowledge and develop skills in handling mental health problems in the community. These consultations are valuable but time consuming and it has been impossible as yet, to have more than the odd one.

The health teams are an experimental attempt to overcome some of the inherent problems of a divided health service by bringing into close relationship the family doctors and local authority community workers. They are 'teams' for the individual and family, in that any one person may have need of many helpers over a period of time and these are co-ordinated, but are predominantly 'teams' for the community of the doctor's practice. The mental health social worker has limited opportunity for preventive work unless it is derived from the family doctor or health visitor. All professions in community work have a mental health role, and in Britain the work is most likely to be co-ordinated effectively if they are gathered around the general practitioners, a large part of whose practice is ineluctably concerned with problems of mental health and mental illness. Doctors may through lack of interest, lack of training and experience or lack of time feel unable to handle what inevitably comes their way. The close attachment of mental health social worker in a broader team approach to the community they serve, allows the family doctor to accept all the problems that come to him, and to provide skilled attention appropiate to the patient's need in the context of his own practice, but without inordinate demands upon his time. We think it works; our only doubts are of the social work resources available to fulfil the growing demand.

As a pioneer scheme we have felt it necessary to attempt some objective assessment of the working of the 'health team' as a whole. An evaluation research project has been undertaken therefore by the University of Manchester, Department of Social and Preventive Medicine.

CHILD GUIDANCE

In the last Annual Report we recorded the establishment of The Family Problem Clinic working alongside the Child Guidance Team. 1966 was our first full year; some progress has been made and some lessons learned.

Although the original team is predominantly involved, the service has grown already beyond us, and has shown such potential for growth as a counselling service for families, that we have now called it The Family Guidance Service. This also links it with the work done by a part-time School Medical Officer for some years.

In general we have retained our original way of working. The P.S.W. largely sees parents whilst the doctor sees the children, the health visitor continuing to liaise with all health visiting staff for referrals and feed-back. We are able also to discuss cases with area health visitors who continue their family care when our involvement has ceased. Most cases still come to us through the health visitors, but others, particularly family doctors, have often expressed concern about these families and asked for what help might be available. At the same time more requests for help have come from other agencies including Probation, School Welfare and Children Department. The request may be for referral but the need must often be seen rather in terms of consultation when professional social workers are already deeply involved in the family. The Mental Health Department has not resources to fulfil this demand, yet there can be little doubt that the felt need is very great. A number of Child Care Officers have expressed their desire for psychiatric help and consultation, particularly for older children in care. School Welfare Officers are less and less tempted to use a simple authoritative approach and turn to the child psychiatric services for help. Teachers ask for help with problems which they know lie in the total family situation, and for children whose emotional problems are too great to handle in the classroom. Family doctors are often anxious about children and families they know need help beyond their time and training. Alongside this widespread awareness of need, there is an equal awareness of the inadequacy of the resources available. Professional social workers in any agency would consider many such problems to lie within their competence, but with inflated case loads and the constant pressure of new cases, they feel unable to spend the necessary time. There is also the temptation to think that psychiatry has the answers to many of these complex emotional and inter-personal problems, when in fact there are few clear answers and even fewer quick and easy ones. And referral is not always advisable; psychiatric consultation when a professional worker is already involved, may offer more realistic help. Unfortunately little can be offered at present.

It is not the least important aspect of our offering an expanded family guidance service, that it has revealed a much greater need than could have been evident to the Child Guidance Clinic alone. Able to handle only a limited number of cases, they always had a long waiting list, which discouraged further referrals. At least one family doctor had not referred any children for five years for this reason. It is significant that currently, as many cases are referred to Family Guidance as to the Child Guidance Clinic proper, in the hope of immediate action.

There is evidence therefore of a considerable demand for a multi-level Child or Family Guidance Service offering not only the exceptional skills of the Child Guidance Team to a few grossly disturbed children and their families, but also direct help and consultation at all levels for a vast number of children and families with problems which, though less severe, might grow and though less extreme, cause much real human suffering.

We are also now able to involve more of our Mental Health Department colleagues in this work. In some cases, after initial assessment and guidance, an appropiate mental health social worker may be able to provide long-term support. Many families referred have long-standing problems hardly soluble in a few interviews, and this practice is likely to continue within the limits of the social work resources available. We can also claim real advances in integration with the Child Guidance Team. The Family Guidance P.S.W. and the Child Guidance P.S.W. meet regularly to survey the waiting lists and new referrals, to organise priorities, and distribute cases as appropriately as possible. We hope that the current year will see the end of long waiting lists and all families referred will be offered some help quickly, whilst the expensive skills of the Child Guidance Team are applied to those who most need them. We have therefore achieved at least the beginnings of Child Guidance screening and a comprehensive family counselling service.

There remain, of course, many problems. Efficiency is difficult to achieve in the absence of proper secretarial help, and both professional teams have suffered. As in other helping agencies, junior clerks come and go too frequently and are seldom equipped for the work of a secretary rather than a filing clerk, and in this situation too much professional time is spent co-ordinating the work. In most cases, the medical officer's work with the children has been largely assessment. This is important but generally demands far less time than the work with parents. Since also a large proportion of children referred are very young, changes in the total situation are going to be effected primarily by the psychiatric social worker's work. It has seemed to us* that for efficient working, one doctor might service three social workers and any expansion of Family Counselling should be seen principally in terms of social work time. Our educational psychologist has up to now been available as needed. We hope that a voluntary worker may be able to help us by looking after children while parents are interviewed.

Most family problems brought our way will not disappear in one or two magic moments. We encourage parents to feel free to contact us later if they wish and we try to follow-up selected cases. Many families are returned to the long-term care of health visitors. With increasing numbers and the complexity of many problems we are tempted to consider special long-term follow-up measures in the form of evening or Saturday morning club facilities. This might provide opportunity for fuller assessment and for individual and group work with parents and children, formally and informally within the club setting. The suggestion remains tentative but we intend to pursue the idea during the coming year.

It is also worth stating that the more we proceed with this work, the more we become aware of the very great and largely unmet need in Salford of group facilities, essentially educational, for pre-school children. Much of this need derives from inadequate housing, but it will be decades, even with the vigour of present programmes, before this is wholly made good, and new flats raise their own problems. We can hope that, following the Plowden Report nursery school places will be rapidly increased, but there will remain an important place for play groups. We will be serving a vital need in terms of family mental health, if we can promote their wide-scale development in Salford.

*c.f. Report of the Underwood Committee on Maladjusted Children, 1955.

THE ADOLESCENT AND MENTAL HEALTH

Introduction

There has recently been expressed a growing concern for the adolescent population, as it has become identified as a moneyed and therefore influential group in society. Publicity has focused upon illegal drug taking, mounting illegitimacy, suicide and attempted suicide and all manner of social disturbance, and has aroused more public outcry than expression of concern. But with recent evidence of drug taking among young people, the distinction between the 'ordinary' teenager and the 'disturbed' has become even more blurred and has provoked in the helping professions great anxiety for the mental health of adolescents in general. At the same time psychiatric and social work circles have become increasingly aware of the singular paucity of facilities for those who are grossly disturbed.

The problems of definition and diagnosis are delicate ones. Most young referrals have either expressed their desire for help or have 'help' thrust upon them for socially unacceptable behaviour. Yet all adolescents to some extent deviate from the norms set by adult society, and all have problems. Most will mature through their problems satisfactorily, but how do we select out those that will not, and what can we do to help? There is little knowledge and much confusion in most of our answers, yet few can doubt the importance of the questions for the future of our society.

The Mental Health Act makes no special mention of young people unless they are mentally subnormal, but the local authority's responsibility is to develop preventive services in addition to caring for the mentally disordered in the community. Should there be special provisions for adolescents in the mental health services? At present there is little, though pressures are mounting upon Regional Hospital Boards and Local Authorities to make good the deficiencies. Adolescents referred must usually take pot luck in the adult services as they stand. For some this may be acceptable, but for most it is not, and we can be sure that inadequate services conceal the true extent of the need. There are hints of this need however, and of the likely demands that the mental health service must face in the future.

E.S.N. School Leavers

Under former legislation, the Education Authority had a statutory duty to notify the Local Health Authority of school leavers requiring further supervision. The 1959 Act permits their referral for care and guidance. The distinction may appear subtle, but there is little doubt that alongside other changes in the mental health services and their legal framework, it has allowed many young people, immature and of low intelligence, to struggle for a number of years with little help under considerable stress. The special school population is selected not only for low intellectual potential but for emotional immaturity and inadequate homes.* Most leavers will mature, probably late, into reasonably competent adulthood, but in the prolonged period of adolescence they and their families may need a great deal of support and guidance. Many do eventually arouse the interest of the mental health service, the youth employment agency, or police and probation: some have worried their family doctors and there is room for improved liaison between these bodies. But since they most need help over the crisis of

* Stein Z.A. and Susser M.W. 1960, Families of Dull Children I, A Classification for Predicting Careers, Br. J. Prev. Soc. Med. 14. 83.

leaving school and settling into work, and the recurrent crises of late adolescence, any realistic offer must be before they leave school.

For some time in Salford, health visitors have worked within the schools with this in mind, but in 1966 a mental health social worker was attached to the special school to try and develop the work further. We hope that she will develop significant enough relationships with the most vulnerable children and their families, to be able to continue to support them through the major crises later. This is little enough, for the shortage of special school places in Salford is such that as many children in need of special education attend ordinary schools as are placed in the special school, and these might be justifiably considered to be at even greater risk. There will indeed, be many other children, not educationally subnormal, who nevertheless face similar problems, and although health visiting and the school welfare service are interested, neither under present circumstances can fulfil the rõle of a school-based social work service. Perhaps eventual re-organisation of social work services will allow higher priority to this aspect of community need.

Formal Mental Illness

Mental disorders have a high incidence in adolescent and early adult years, yet the psychiatric services have barely recognised until recently that they must cope with a large proportion of young people with the additional problems of their age. Difficulties of diagnosis are accentuated in a group notable for the variety and eccentricity of normal behaviour patterns. The clinical pattern of psychosis is very variable and the response to physical treatments difficult to assess, when there is the possible admixture of adolescent identity crises. A group with 'formal' mental illness therefore, broadly overlaps the group of psycho-social disorders which may or may not draw the attention of psychiatrists. In the Edinburgh Survey of mental illness in adolescence,* only seven per cent of inceptors aged fourteen to nineteen were diagnosed psychotic, none of these having attempted suicide. About half those referred were seen only once by the psychiatrist, and the survey revealed little demand from this age group for the existing adult psychiatric services but a very great demand for at least a counselling service. It seems likely that the present hospital and local authority psychiatric services are relatively little used by adolescents because they are in most cases inappropriate, and would be even less used were there available a realistic alternative.

The Disturbed Adolescent

From the Edinburgh Survey and our own experience there seems to be relatively few adolescent disorders readily diagnosed, and treated by physical methods, after the manner of adult psychiatry, and formal diagnostic labels may prove more inhibiting than useful. Nor are the child psychiatric services any less inappropriate, and indeed, the medical model itself is of doubtful convenience. Any offer of help, if it is to be realistic, must therefore be empirical and experimental.

All social agencies are interested in this group for all have some adolescent clients. Psychiatrists and mental health social workers see the grossly disturbed and the self-injured. Children Departments have adolescents in care with the special problem of their future at 18. Child guidance agencies

* Henderson A.S., McCulloch J.W., and Phillip A.E. 1967, Survey of Mental Illness in Adolescence, B.M.J. 1. 83.

see some, and student health services many, with emotional problems, while others seek help through the youth services, moral welfare agencies and the churches. Delinquency, drugs and alcohol interest probation and police. Yet few professional agencies could claim much confidence in handling their disturbed adolescent clients, and none would accept the responsibility for the group as a whole. Our experience in Salford is that these agencies tend to look to psychiatry to give them 'the answers' and to take over their clients, but psychiatry does not have all the answers and the psychiatric services are not necessarily the most appropriate. Nevertheless a community mental health service must be concerned.

What little we are doing has developed ad hoc from the psychiatric day centre in its relationship to the general hospital unit which admits a mixed group of patients with a bias towards the neuroses. The relative freedom of a small unit and the potential for group work are countered by the restrictions of the accommodation but our day centre is close enough to allow patients on the ward to use it each afternoon. Thus the day centre group may comprise people who have never been in hospital, those currently on the ward and some who have been discharged. The therapist is in close contact with hospital staff, participating in case conferences, 'ward rounds' and the patient-staff meeting, and maintaining informal contact with patients in and out of hospital. The Cleveland Club, described elsewhere in this report, extends the work one evening a week. This pattern was not developed with adolescents in mind, but it has become obvious over the past year that this is the group best able to use the freedom and informality of the joint arrangements. The increasing demands of younger patients have tempted the therapist to offer more evenings and weekends, and it is only because of her unusual interest and exceptional abilities that she has been able to cope with the demand and establish a widening circle of contacts amongst young people not otherwise known to the service.

The imaginative and free approach necessary for this work inevitably arouses conflicts. It is not easy for hospitals to allow freedom of movement even late at night or local authority staff to cope with extended hours and unconventional activities. Moreover, disturbed adolescents are likely to promote an image of day centre and hospital which discourages other patients and antagonises the general public. We are thankful for the degree of freedom achieved, but if this work increases these difficulties may become important.

With so little firm knowledge we can only plan to be flexible. We need more extensive accommodation with more separate rooms which can be varied in use according to group needs. A new building would hardly be appropiate; older converted property of a much rougher kind would be more suitable. But though local authorities can readily retain poor buildings over long periods when already in use, it is difficult to set up a new establishment in poor quality accommodation. Yet this is what we need.

It could also be that the restrictions of public accountability and the inertia of bureaucracy and the cumbersome machinery of Local Government are incompatible with the demands of such an experimental service, and that the traditional role of voluntary bodies as pioneers in new areas of need will be necessary.

Students

The advent of a new university in the City of Salford presages a large scale increase in the number of students seeking some sort of psychiatric help; a number already have come our way and some are to be found in the adolescent group described above. A large proportion of students are resident in the City, in Halls of Residence or in lodgings. They are a known vulnerable population and we can expect them increasingly to call upon the mental health services unless adequate student health facilities are developed by the university itself. Evidence from older universities* suggests that student health services predominantly handle a multiplicity of emotional and psycho-social problems which fall well within the mental health sphere of interest. A psychiatric service is not so much needed as a much broader counselling service, associated perhaps with an efficient tutorial system and this must draw counsellors from the social work professions. It is of interest that already some informal links have been built up between the university and the community mental health social workers, P.S.W's having been brought in by tutors and the general practitioner attached to the Hall of Residence, to provide counselling. We are happy to offer such a service within the limits of our staffing, but we may be unable to cope with the eventual demand of a rapidly growing student population. It may be that a student counselling service could best be developed jointly by mental health department and university.

We have discussed a few aspects of the needs of this important age group. Any broader interest and any thought of preventive work must involve us with the school population. Preventive work in terms of health education is undertaken by health visiting staff, though 'mental health week' brings opportunities of more direct involvement by mental health social workers and doctors. We must not minimise the importance of current work, but it is a meagre offering compared to that which waits to be done. Most children must face their first adolescent problems whilst still at school and counselling must begin here if it is to be truly preventive.

* Report of the Committee on Student Health, April 1967, Oxford Univ. Gazette.

APPENDIX I

Sources of Referral for Mental Illness to Salford Mental Health Service in 1966
(and Percentage of Total Notifications)

Agency	Male	Female	Total
General Practice	87 (35%)	190 (44%)	277 (40%)
Health/Welfare/Voluntary Organisation	20 (8%)	53 (12%)	73 (11%)
Police/N.S.P.C.C.	13 (5%)	18 (4%)	31 (5%)
Hospital Psychiatrist	36 (14%)	65 (15%)	101 (15%)
General Hospital	9 (4%)	6 (1.5%)	15 (2%)
Relatives	40 (16%)	48 (11%)	88 (13%)
Other	45 (18%)	54 (12%)	99 (14%)
TOTAL	250	434	684

* These figures do not take into account 36 referrals from Psychiatric Outpatients for Social Histories; 23 cases of Other Authorities; 34 cases under 16 years of age and 64 referrals demanding No Further Action after initial investigation.

APPENDIX IIA

All Notifications of Female Patients Referred for Mental Illness to Salford Mental Health Service, 1966 by Source of Referral and Disposal (Percentages)

Disposal	G.P.	Health/ Welfare/ Voluntary Organisation	Police/ N.S.P.C.C.	Hospital Psychiatrist	General Hospital	Relatives	Other	Total Number	Total %
Compulsory Admission	12%	9%	33%	9%	17%	14%	6%	52	12%
Voluntary Admission Day Patients	26%	13%	28%	29%	–	29%	13%	105	24%
Psychiatric Outpatients Domiciliary Visit	14%	9%	11%	11%	17%	4%	8%	47	11%
Home Support and G.P.	38%	60%	28%	43%	50%	41%	57%	191	44%
Other	8%	7%	–	7%	17%	10%	17%	39	9%
Total Number	190	53	18	65	6	48	54	434	–
Percentage of Total Referrals of Female Patients	44%	12%	4%	15%	1.5%	11%	12%	–	100%

APPENDIX IIB

All Notifications of Male Patients Referred for Mental Illness to Salford Mental Health Service in 1966 by Source of Referral and Disposal (Percentages)

Disposal	G.P.	Health/ Welfare/ Voluntary Organisation	Police/ N.S.P.C.C.	Hospital Psychiatrist	General Hospital	Relatives	Other	Total Number	Total %
Compulsory Admission	15%	15%	38%	6%	33%	15%	4%	34	14%
Voluntary Admission Day Patient	32%	15%	7%	22%	11%	20%	22%	60	24%
Psychiatric Outpatient Domiciliary Visit	10%	5%	–	22%	–	5%	13%	26	10%
Home Support and G.P.	33%	50%	46%	44%	44%	48%	60%	111	44%
Other	8%	15%	7%	6%	11%	13%	–	19	8%
Total Number	87	20	13	36	9	40	45	250	–
Percentage of Total Referrals of Male Patients	35%	8%	5%	14%	4%	16%	18%	–	100%

APPENDIX III

Disposal of All Patients Referred to Mental Health Service

Agency	1962		1963		1964		1965		1966	
Compulsory Admission	53	35%	105	41%	98	40%	70	42%	62	34%
Voluntary Admission	111		101		116		128		126	
Outpatients and Domiciliary Visits	86		61		61		72		67	
Home and G.P.	157	65%	157	59%	218	60%	174	58%	246	66%
Other	60		84		39		30		48	
TOTAL	467		508		532		474		549	

APPENDIX IV

The Case Load of the Mental Welfare Officer

	1961	1962	1963	1964	1965	1966
A. Mental Illness						
Number of new patients referred	255	260	298	301	246	278
Number of known patients referred	215	207	210	231	228	270
Total Patients referred	470	467	508	532	474	548
Second and subsequent referrals during calendar year	85	122	85	125	98	136
Total referrals	555	589	593	657	572	684
Mental Subnormality						
Number of new patients referred	26	29	32	60	34	36
Total New Patients Referred:						
Mental Illness and Mental Subnormality	281	289	330	361	280	314
B. Total number of visits†	6,752	7,849	9,992	9,579	6,182	8,084
Number of officers (full-time equivalents per annum)	5.06*	6.63*	9.03*	9.13*	7.42*	8.00*
Average number of visits per officer	1,334	1,184	1,106	1,049	820	1,010
C. Average number of new patients referred per officer	56	44	36	40	38	39
Average number of known patients referred per officer	42	31	23	25	31	34
Average number of referrals per officer	114	93	69	79	82	90
D. Average number of visits per new patient referred	24	27	30	26	23	26
[x]Average number of visits per total referrals	11	13	16	13	10	11

† Includes office interviews, visits to hospitals, etc.

* Excludes Trainees.

[x] This average is inflated because it includes visits to known subnormal patients who are not included in referrals.

N.B. See also Appendix I.

APPENDIX V

New Notifications of Mentally Subnormal Persons, 1966, by Sex, Grade and Age

Age	0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50 +	Total
Males									
Severely Subnormal	4	1	1	–	–	–	1	–	7
Subnormal	–	–	–	5	–	2	–	–	7
Not yet Assessed	6	–	–	–	–	–	1	–	7
TOTAL	10	1	1	5	–	2	2	–	21
Females									
Severely Subnormal	2	–	2	1	–	–	–	1	6
Subnormal	2	–	–	1	–	1	1	–	5
Not yet Assessed	3	–	–	–	1	–	–	–	4
TOTAL	7	–	2	2	1	1	1	1	15
TOTAL Males and Females	17	1	3	7	1	3	3	1	36

APPENDIX VI

New Notifications of Mentally Subnormal Persons, 1966, by Age and Source of Referral

Source / Age	0 – 4	5 – 9	10 – 14	15 – 19	20 – 29	30 – 39	40 – 49	50+	Total
Maternity and Child Welfare	17	–	–	–	–	–	–	–	17
Education Department	–	–	1	1	–	–	–	–	2
Hospital Services	–	–	–	2	–	–	3	1	6
Immigration	–	1	1	–	1	–	–	–	3
Others	–	–	1	4	–	3	–	–	8
TOTAL	17	1	3	7	1	3	3	1	36

APPENDIX VII

New Notifications of All Mentally Subnormal Persons 1959 – 1966
Age Groups : 0 – 4 years and 15 – 19 years

Age / Year	0 – 4 years		15 – 19 years		Percentage both Groups	Total Notifications at all ages
	Number	Percentage of total Notifications	Number	Percentage of total Notifications		
1959	13	32%	12	29%	61%	41
1960	7	18%	19	50%	68%	38
1961	11	42%	3	12%	54%	26
1962	17	59%	4	14%	73%	29
1963	21	68%	3	10%	78%	31
1964	24	39%	16	27%	66%	62
1965	13	38%	11	32%	70%	34
1966	17	47%	7	19%	66%	36

APPENDIX VIIIA

New Notification 1963 – 1966 of Mentally Subnormal Persons
under Five years of Age

Age	0 –	1 –	2 –	3 –	4 –	Total 0 – 4
1963	1	1	9	8	2	21
1964	3	6	9	4	2	24
1965	2	3	5	3	–	13
1966	–	3	6	7	1	17

APPENDIX VIIIB

New Notifications to Mental Health Department during 1965 & 1966, Aged 0 – 4 Years
Age of original Notification to Health Department (M. & C.H.)

Age	0 –	1 –	2 –	3 –	4 –	Total
1965	9	1	2	1	–	13
1966	7	3	5	1	1	17

5 Cases were referred during the first month of life.
A number of the others had been under observation as 'at risk' for some time.
2 Cases referred at 2 and 4 years, were immigrants to Salford.

APPENDIX IX

Alterations in Status of Mentally Subnormal Persons on the Salford Register during 1966 by Age and Sex

	MALES									FEMALES									Total Males and Females
	AGE								Total	AGE								Total	
	0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+		0–4	5–9	10–14	15–19	20–29	30–39	40–49	50+		
Discharged from care	1	–	1	–	14	4	2	–	22	1	1	–	–	10	–	–	2	14	36
Migration out of Salford	–	1	–	2	6	3	8	3	23	1	–	–	1	3	3	2	1	11	34
Deaths	1	1	–	–	–	–	4	3	9	1	–	–	–	–	1	–	4	6	15
Not located	–	–	–	–	5	2	–	1	8	–	–	–	–	4	1	–	–	5	13
									62									36	98
Discharged from Hospital	–	–	–	1	2	–	–	–	3	–	–	–	–	1	–	1	1	3	6
Admitted to Hospital	1	–	–	2	–	1	1	–	5	–	1	1	–	–	2	–	–	4	9

Admitted to Hospital Short-Term Care during 1966 – 17 Persons for 20 Periods.

APPENDIX X

Adult Day Centres – Registers, Admissions and Discharges for 1964 – 1966

	MEN			WOMEN			ALL		
	Mentally Subnormal	Mentally Ill	Total	Mentally Subnormal	Mentally Ill	Total	Mentally Subnormal	Mentally Ill	Total
Number on registers 31.12.1964	57	15	72	34	43	77	91	58	149
Number on registers 31.12.1965	49	27	76	31	65	96	80	92	172
Number on registers 31.12.1966	49	24	73	26	45	71	75	69	144
Average daily attendance 1964									113
Average daily attendance 1965									120
Average daily attendance 1966									121
Number of admissions 1964	35	22	57	32	69	101	67	91	158
Number of admissions 1965	23	44	67	21	103	124	44	147	191
Number of admissions 1966	32	82	114	9	176	185	41	258	299
Discharges 1964	22	28	50	40	54	94	62	82	144
Discharges 1965	31	32	63	24	81	105	55	113	168
Discharges 1966	32	85	117	14	196	210	46	281	327
Discharges 1966									
Work	4	47	51	3	47	50	7	94	101
Household Duties	–	–	–	2	94	96	2	94	96
Migrated	–	–	–	1	2	3	1	2	3
Transferred to other Centres	10	5	15	3	8	11	13	13	26
Defaulted	11	3	14	3	15	18	14	18	32
Rehabilitation Unit	2	5	7	–	1	1	2	6	8
Died	2	1	3	–	2	2	2	3	5
Sick	–	1	1	–	–	–	–	1	1
Hospital	3	15	18	2	19	21	5	34	39
Miscellaneous	–	8	8	–	8	8	–	16	16

N.B. Discharges to work and household duties in 1966 includes many who attended Cleveland Day Centre whilst being in-patients in Hope Hospital.

APPENDIX XI

Trainees entering employment from Adult Training Centres or Out-workers Register in 1966

	Age	Period Unemployed	Centre Attendance	Centre Attended	Type of Employment	Results
Mentally Ill Males	52	Sporadic jobs	One week	Out-workers	Labourer - Steel Works	For 7 months, returned to centre
	52	Sporadic jobs	Three weeks	Out-workers	Kitchen Porter	Stable
	47	Fifteen years	Twelve months	Out-workers	Kitchen Porter	Stable
	42	Hospitalised over a long period	Four months	Acton Square	Porter – Manchester University	Stable
	38	Four years	Twelve months	Acton Square	Caretaker – Salford Corporation	Stable
	24	Sporadic jobs	Seven months	Acton Square	Labourer - British Rail	Two weeks, returned to centre
	44	Sporadic jobs	Twelve months	Acton Square	Labourer	Stable
	30	One year	Two months	Acton Square	Labourer - Printing Firm	Stable
	27	One year	One month	Acton Square	Labourer - Waterproofing Firm	Stable
	24	Two years	Two weeks	Acton Square	Labourer - Cement Firm	Stable
	55	Hospitalised for a long period	Two weeks	Acton Square	Warehouseman	Stable
	19	Six months	One week	Acton Square	Light engineering work	Stable
	53	Many years hospitalised	Three weeks	Acton Square	Porter - Jewish Hostel	Stable
	52	One year	Two weeks	Acton Square	Labourer - Building Firm	Stable
	60	Sporadic jobs	Six months	Hulme Street	Wire-Working Firm	Stable
Mentally Ill Females	45	Several years hospitalised	Two months	Out-workers	Cleaner – Restaurant	Stable
	56	Nine months	Three months	Out-workers	Cleaner – Salford Corporation	Stable

APPENDIX XI (continued)

Trainees entering employment from Adult Training Centres or Out-workers Register in 1966

	Age	Period Unemployed	Centre Attendance	Centre Attended	Type of Employment	Result
Subnormal Males	16	Never worked before	Eighteen months	Acton Square	Warehouse Assistant	Stable
	19	Sporadic jobs	Six months	Hulme Street	Kennel hand	Stable
	28	Never worked before	Also attended at Junior Centre	Hulme Street	Filing Clerk-D.L.B. Dept.	Stable
	20	Sporadic jobs	Three weeks	Hulme Street	Market Porter	Stable
Subnormal Females	24	Sporadic jobs	One week	Out-workers	Machine Operator — Box Making Firm	Stable
	60	Several years hospitalised	Three months	Out-workers	Kitchen Maid	Stable

APPENDIX XII

HOSTELS: Residence, Admissions, Discharges 1964 – 1966

	MEN			WOMEN			ALL		
	1964	1965	1966	1964	1965	1966	1964	1965	1966
ADMISSIONS									
One admission only	27	26	16	27	25	20	54	51	36
More than one admission	1	3	–	6	5	3	7	8	3
Reasons for Admission									
No Home	3	11	2	7	11	8	10	22	10
Lack of economic resources	3	2	–	–	5	–	3	7	–
Half-Way House from Hospital	15	6	10	10	2	7	25	8	17
Need for Protected Environment	2	2	4	4	6	8	6	8	12
Short-Term Care	6	9	–	8	4	1	14	13	1
Domestic Tension	–	3	1	12	1	3	12	4	4
Leave from Hospital	1	–	–	6	4	–	7	4	–
En Route to Hospital	–	–	–	–	3	1	–	3	1
Diagnosis									
Psychosis	12	22	12	15	15	19	27	37	31
High-Grade Subnormality	3	3	1	15	10	5	18	13	6
Medium-Grade Subnormality	14	8	2	10	7	2	24	15	4
Neurosis	–	–	1	–	1	2	–	1	3
Psychopathy	1	–	1	1	3	–	2	3	1
Not Determined	–	–	–	6	–	–	6	–	–
Age Groups									
15 – 24	8	7	3	13	5	4	21	12	7
25 – 34	2	2	2	9	8	8	11	10	10
35 – 44	11	11	6	14	6	3	25	17	9
45 – 54	8	8	6	8	7	8	16	15	14
55 – 64	7	4	–	6	8	5	13	12	5
65+	–	1	–	–	2	–	–	3	–
Number obtained employment after admission	10	8	9	13	13	19	23	21	28

APPENDIX XII (continued)

HOSTELS: Residence, Admissions, Discharges 1964–1966

	MEN			WOMEN			ALL		
	1964	1965	1966	1964	1965	1966	1964	1965	1966
DISCHARGES									
One discharge only	18	26	16	24	23	18	42	49	34
More than one discharge	1	3	3	11	4	3	12	7	6
Duration of Stay									
<1 month	10	16	7	28	12	6	38	28	13
1 month–	6	6	3	8	8	6	14	14	9
3 months–	2	4	6	5	6	4	7	10	10
6 months–	1	2	2	–	3	4	1	5	6
9 months–	1	1	1	1	1	2	2	2	3
12 months–	1	4	4	7	2	4	8	6	8
Outcome									
Satisfactory	16	27	13	37	22	18	53	49	31
Left by agreement	–	5	2	4	5	4	4	10	6
Placement (Home, Lodging, Foster-care)	9	14	7	22	7	10	31	21	17
Return home after short-term care	6	8	2	7	4	2	13	12	4
Following leave from hospital	1	–	–	4	3	–	5	3	–
En Route to hospital	–	–	–	–	3	2	–	3	2
Excluded	–	–	2	–	–	–	–	–	2
Unsatisfactory	5	6	10	12	10	8	17	16	18
Deterioration & admission to hospital	2	3	6	3	9	7	5	12	13
Delinquency and Court action	–	–	2	–	–	–	–	–	2
Left without consultation	3	3	2	8	1	–	11	4	2
Expelled	–	–	–	1	–	1	1	–	1

APPENDIX XIIIA

Patients in Residence in Hostels, by Age and Sex

MEN	15 – 24	25 – 34	35 – 44	45 +	ALL
At 31.12.65	–	–	7	11	18
At 31.12.66	–	1	3	8	12
WOMEN					
At 31.12.65	1	3	8	8	20
At 31.12.66	1	5	5	11	22
TOTAL					
At 31.12.65	1	3	15	19	38
At 31.12.66	1	6	8	19	34

APPENDIX XIIIB

Patients in Residence in Hostels, by Diagnosis and Sex

MEN	Psychosis	High Grade Sub-Normal	Medium Grade Sub-Normal	Neurosis	Psychopath	Total
At 31.12.65	12	–	5	–	1	18
At 31.12.66	6	–	5	1	–	12
WOMEN						
At 31.12.65	5	5	9	1	–	20
At 31.12.66	12	3	6	1	–	22
TOTAL						
At 31.12.65	17	5	14	1	1	38
At 31.12.66	18	3	11	2	–	34

APPENDIX XIIIC

Patients in Residence in Hostels, by Duration of Stay

	Less than 1 month	1 month	3 months	6 months	9 months	12 months	Median
At 31.12.65	8	2	7	4	2	15	6 months
At 31.12.66	3	5	5	3	1	17	9 months

APPENDIX XIIID

Patients in Residence in Hostels, by Employment

	MEN		WOMEN		ALL	
	Working	Unemployed	Working	Unemployed	Working	Unemployed
At 31.12.65	3	15	9	11	12	26
At 31.12.66	4	8	9	13	13	21

APPENDIX XIV

Mental Health Department – Staff

	31.12.1965	Resigned 1966	Appointed 1966	31.12.1966
MEDICAL				
Senior Assistant Medical Officer	1	–	–	1
CONSULTANTS				
Psychiatrist (one session per week)	1	–	–	1
Paediatrician (one session per week)	1	–	–	1
EDUCATIONAL				
Educational Organiser (to be designated Centre Organiser)	1	1	–	–
Psychologists (sessional work)	3	–	–	3
SOCIAL WORKERS				
Chief Mental Welfare Officer	1	–	–	1
Deputy Chief Mental Welfare Officer	1	–	–	1
Psychiatric Social Workers	1 (part-time)	–	1 (part-time)	2 (part-time)
Mental Welfare Officers	6 (inc. 1 part-time)	2	1	5 (inc. 1 part-time)
Trainee Mental Welfare Officers	–	–	2	2
ADMINISTRATION				
Administrative Assistant	1	1	1	1
Clerks	2	1	1	2
Typists	2	–	–	2
TRAINING CENTRES				
Supervisors	4	1	1 (acting sup.)	4
Assistant Supervisors	20 (inc. 1 temp.)	4 (inc. 1 temp.)	3 (inc. 2 temp.)	19 (inc. 2 temp.)
Centre Assistants	3	–	–	3
RESIDENTIAL HOSTELS				
Wardens	2	1	1	2
Assistant Wardens	1	–	1	2

IMMUNISATION SECTION

2,388 children in the age group 0 – 15 years completed a course of immunisation during the year.

Below are the statistics relating to the year's work :–

	0 – 5 years	5 – 15 years	0 – 15 years
Number immunised during the year ended 31st December, 1966	2,328	60	2,388
Total completed immunisation at 31st December, 1966	9,802	20,044	29,846
Population figures, 1966	14,000	21,000	35,000
Percentage immunised at 31st December, 1966	70%	95.4%	85.2%

The children were immunised as follows :–

At child welfare centres	1,561
By public health nursing staff in the homes of the children	638
By nursing staff at schools	60
By general practitioners	125
At Greenbank Nursery	4
	2,388

Of the 2,388 children completing immunisation, 2,328 received diphtheria, pertussis and tetanus (triple antigen) and 60 received diphtheria and tetanus injections. 1,758 booster doses of diphtheria and tetanus were given to school children during 1966 and 1,348 children aged 0 – 5 years were given a booster dose of triple antigen twelve months after the completion of primary immunisation.

WHOOPING COUGH IMMUNISATION

2,328 children received whooping cough immunisation during the year (all these children were given triple antigen injections).

POLIOMYELITIS VACCINATION

The following figures show the number of children who have completed a course of oral poliomyelitis vaccination during the year :–

	3rd dose	4th dose
Children 0 – 5 years (1962–1966)	2,413	1,346
Children 5 – 15 years (1952–1961)	1,358	838
Young people (age group 1933–1951)	229	–
Older people up to 40 years of age	145	–

The figures below show the total number of poliomyelitis vaccinations given at 31st December, 1966 :–

	Completed Salk & Oral Vaccine		Booster Salk & Oral Vaccine
0 – 5 years (1962–1966)	9,060	63%	2,695
5 – 15 years (1952–1961)	21,584	97%	26,470
0 – 15 years (1952–1966)	30,644	84%	29,165
Young Persons (1933–1951)	27,086	60%	7,468
Older people to 40 years of age	8,576	15%	–

B.C.G. VACCINATION

The figures following show the number of Mantoux tests and B.C.G. vaccinations given to 13 year old children and older children who had missed previous vaccination sessions :–

	Consents	Positive	Negative	D.N.A.	B.C.G. Vaccinations
Boys	888	38	580	270	580
Girls	962	45	626	291	626
Totals	1,850	83	1,206	561	1,206

Mantoux investigation at Tootal Drive School on 21st November, 1966 :–

13 Positive and 38 negatives.

SMALLPOX VACCINATION

Below are statistics relating to smallpox vaccinations given to children during the year :–

Age at date of vaccination in the year	Under 1 year	1 year	2 – 4 years	5 – 14 years	15 years and over	Totals
Primary vaccinations	112	740	642	244	208	1,946
Re-vaccinations	–	–	32	417	870	1,319

During the summer, cases of variola minor, a mild form of smallpox, occurred in Salford. All the known contacts were vaccinated and this explains the increase in the number of children and adults vaccinated.

Because of really low numbers of young children attending clinics for smallpox vaccination, it was decided during October that better attendances might be obtained if mothers were invited to bring their children to the clinics soon after the children had reached their first birthday. Previously, nurses at the clinics had asked mothers to attend after the children had received a booster dose of triple antigen.

INFECTIOUS DISEASES

The following table shows the number of infectious diseases notified during the year :–

Disease	All ages	Under 1 year	1 – 5 years	5 – 15 years	15 – 25 years	25 – 45 years	45 – 65 years	65 years and over
Scarlet Fever	34	–	15	17	2	–	–	–
Whooping Cough	26	1	19	5	1	–	–	–
Measles	1,190	63	745	374	8	–	–	–
Dysentery	32	1	17	7	5	2	–	–
Pneumonia	3	–	–	1	–	1	–	1
Erysipelas	2	–	–	–	–	–	1	1
Food Poisoning	14	–	1	4	5	2	2	–
Puerperal Pyrexia	23	–	–	–	13	10	–	–
Rheumatism	2	–	–	2	–	–	–	–
Meningococcal Infection	4	–	2	2	–	–	–	–
Typhoid Fever	2	–	–	2	–	–	–	–
Smallpox	7	–	4	1	–	1	1	–
Tuberculosis (respiratory)	71	–	–	2	10	19	31	9
Tuberculosis (others)	5	–	2	1	–	2	–	–
Totals	1,415	65	805	418	44	37	35	11

AMBULANCE SERVICE

The following tables give particulars of patients carried and mileage run during 1966, as compared with the previous year:–

Class of Patient	1966		1965	
	Patients	Miles	Patients	Miles
House Conveyance	64,392	167,400	62,041	159,089
Inter-Hospital	2,821	14,714	2,508	13,958
Maternity	1,551	9,666	1,593	10,195
Mental Health Hospitals	9,168	13,339	7,609	12,336
Rechargeable to Other Authorities	324	2,634	208	2,210
Emergency	5,283	21,355	4,938	20,532
Infectious	29	235	12	87
Miscellaneous	–	2,966	–	3,519
TOTAL	83,568	232,309	78,909	221,926
Class of Vehicle				
Ambulance	75,429	194,734	71,010	187,748
Car	8,139	37,575	7,899	34,178
TOTAL	83,568	232,309	78,909	221,926

Other than Section 27 Patients – for Recharge

Class of Patient	1966		1965	
	Patients	Miles	Patients	Miles
Midwives	*1,171**	7,148	*1,427**	8,974
Gas/Air	*408**	1,553	*468**	1,575
Premcots	*108**	504	*93**	439
Mental Health (Centres)	15,664	16,131	15,791	16,065
Handicapped Persons	2,112	1,488	2,422	1,718
Spastics	5,290	7,121	4,624	5,936
TOTAL	23,066	33,945	22,837	34,707

* *Visits*

TOTAL PATIENTS CARRIED AND MILEAGE RUN

	1966	*1965*
Patients carried	106,634	101,746
Mileage Run	266,254	256,633

During the year, the ambulances carried 98,310 patients and travelled 220,466 miles, and the sitting-case cars carried 8,324 patients and travelled 45,788 miles.

At the end of the year there were in operation 11 ambulances, 4 sitting-case ambulances and 2 sitting-case cars. In addition, there is a 20-seater sitting-coach which has been donated by the Variety Club of Great Britain.

The staff consists of an Ambulance Officer, a Deputy Ambulance Officer, a Station Officer, three Shift Leaders, 42 Driver/Attendants, a Radio-telephone Operator, and a General Duties Man.

Twelve vehicles are now painted white, a colour which is being gradually extended to the whole fleet.

HEALTH EDUCATION

ANTI-ADDICTION CLINIC

Weekly sessions of the anti-addiction clinic have continued throughout the year. Although the bulk of attenders want to give up smoking, problems of obesity, drug addiction and gambling are also welcome.

Anti-Smoking

273 people attended for the first time during 1966, giving a total of 570 attendances at 47 sessions (average attendance, therefore 12). Numbers, as always, have fluctuated, the highest attendance being 50 but on four occasions there were fewer than five. 43 people were successful in stopping smoking and 60 reduced the number of cigarettes smoked by more than 50%.

Although this shows a decrease in attendances during 1966, it seems fair to mention that cigarette smoking throughout the country has also decreased, thus the efforts of the Ministry of Health and the local authority have been slightly rewarded.

FIVE DAY PLAN TO GIVE UP SMOKING

In addition to the regular Monday clinic a "FIVE DAY PLAN TO GIVE UP SMOKING" was held in October/November. Lectures and films were given by the British Temperance Association. 50 people attended the course but 26 only attended 3 or more nights, and 20 people attended only one night. There were 35 males and 15 females.

Of the 26 who attended 3 or more times, it was discovered that 18 had stopped smoking and 8 had reduced the number of cigarettes smoked.

A re-union was held six weeks after the course. Only 8 of the above 26 attended, 6 of whom had not smoked since the course, one had stopped between the course and re-union and one had stopped for 2 weeks and re-commenced. One telephoned that he could not attend the re-union but had stopped as a result of the Five Day Plan.

REVIEW OF ANTI-SMOKING CLINICS 1962 to 1966

During the summer of 1966 a questionnaire was sent to persons who had attended these clinics from 1st January 1962 to 31st March 1966. The object was to assess the success of the clinics, attendances at which had increased during the period.

Year	Number of Attendances
1962	64
1963	100
1964	141
1965	295
1966 (first quarter only)	136

In addition to those attending the regular clinics, in 1965 90 persons attended an intensive "5 day plan" to give up smoking. A further "5 day plan" was held in December 1966.

Because of difficulties in tracing people who lived outside Salford and the high removal rate of persons living within the City completed questionnaires were received from only 457 (56%) of those who had attended.

Although only 87 persons (19%) had stopped smoking (71 for at least 3 months) a further 143 (31%) had reduced their cigarette smoking.

One of the greatest difficulties in assessing the success of specialised health advisory clinics, such as the anti-smoking clinic, by subsequent follow-up is that it is very difficult to establish what proportion of people would have given up smoking even if they had not attended. However, 80 persons who had stopped smoking definitely thought that attendance at the clinic had helped them to break the habit.

A detailed analysis of the answers given on the questionnaire was carried out using the City's computer.

Only slightly more males (52%) than females had attended. Over half of those who had attended were aged 30 to 50 years.

Since the clinics had started it had been observed that many people only attended once or twice. It had been thought that we had either failed to interest people or that they themselves had abandoned the idea of attempting to stop smoking. Surprisingly, the answers to the questionnaire showed that the number of attendances was not so important as we had thought; 23 of the 87 who had stopped smoking had been only once and a further 18 twice. Of the 143 who had reduced their cigarette consumption 90 had not attended on more than two occasions.

The ill-effects of smoking on health, particularly as a causative factor in cancer of the lung, chronic bronchitis and coronary thrombosis are well established and any health education programme should continue to advise against cigarette smoking and provide help for those who wish, or must, for health reasons give up the habit.

HOME SAFETY

Home Accidents Treated at Salford Royal Hospital during 1966

	Male		Female		Total	
	Fatal	Non-fatal	Fatal	Non-fatal	Fatal	Non-fatal
Burns and Scalds	–	242	3	251	3	493
Falls	5	693	21	902	26	1,595
Lacerations	–	295	–	273	–	568
Poisoning	–	118	1	90	1	208
Overdose	3	107	8	155	11	262
Dog and Cat Bites	–	47	–	47	–	94
Assaults	–	29	–	76	–	105
Gas Poisoning	–	3	1	12	1	15
Swallowed Foreign Bodies	–	74	–	92	–	166
Miscellaneous	–	1,820	–	1,482	–	3,302
TOTALS	8	3,428	34	3,380	42	6,808
	(10)	(3,531)	(22)	(3,342)	(32)	(6,873)

1965 figures in brackets

Although the number of home accidents treated has decreased slightly it is regretted that the fatalities have increased during 1966. It appears that our aim in the future should be to help the elderly to live a safer life at home and thus prevent the further loss of life of our citizens, because of falls, which can so easily be prevented.

HEALTH CHECK-UP

This year the Health Check Up, organised at the Crescent Health Department from July 18th to September 2nd, was limited to residents of Salford and anyone who worked in Salford although residing outside the City boundary. It was carried out in conjunction with the Mass Radiography Service operating in the basement of the Health Department.

In the main entrance hall the clinical tests were performed, and each individual on arrival was asked to complete a form giving personal details of age, address, name of G.P., marital status, occupation and details of any clinical symptoms, smoking habits, together with information as to whether medical care was being received. On this form were recorded the results of the various tests. These included measurements of height, weight, blood pressure, haemoglobin, vision tests for both near and distant vision, urine tests for glycosuria and a foot inspection. A cervical smear test was available or an appointment for this could be made.

All the results of each individual were sent to the family doctor; it was felt that the responsibility for further investigation, if necessary rested with him and the local medical committee had previously been consulted and agreed to the procedure.

For the analysis of the results the following standards were used:

Blood Pressure

Systolic reading below 159 mms Hg with diastolic reading below 84 mms H8.

Heamoglobin

Men: above 85% 12.5 gr. Hb per 100 ccs and women above 80% gr. Hb per 100 ccs.

Vision

Better than $^{6}/_{12}$ using both eyes and glasses if worn.

Urine

Absence of glucose.

Weight

Below average weight or 10% and more above average weight for age and height.

The tests were carried out under medical supervision but nursing staff were necessary to take blood pressure and haemoglobin, the vision screening machine was used by specially trained nursing staff, and other tests were carried out by nursing auxiliary staff. The foot inspection was carried out by the Chief Chiropodist employed by the Health Department.

For the urine test persons attending were given a Clinistix in a small envelope on which were printed full instructions for testing their own urine. It was requested that the results be noted on the envelope and returned to the Medical Officer of Health. There was a poor response to this method and only one-third of the envelopes were returned.

Results

A total number of 3,493 individuals attended the Health Check Up (average 470 per week) in which 19,138 tests were performed.

Excluding the measurements of height and weight and the results of the foot inspection, it was found that 24% of those tested had an abnormal clinical result which required further observation or treatment. If the results of foot inspection and weight measurements are included almost 35% of these tested were found to require further medical attention.

The largest amount of clinical defect was revealed by the vision tests. 66.8% of the people had a defect of either near or distant vision or both. Of those individuals who wore glasses only 18.1% passed the test for both near and distant vision and 42.6% failed both these tests. Comparable figures for the individuals not wearing glasses were 49.3% (pass in both near and distant vision) and 18.6% (failed in both near and distant vision).

17.2% of the people were found to be anaemic. This was more severe in females than males and was also shown to be more frequent in Salford residents when compared with non-Salford residents. The latter fact can be partly explained by the social class structure of the non-Salford residents which had a larger number of people from the higher social economic groups.

Unfortunately the method used for the urine examination was not satisfactory, giving only a 45% return of the total number of Clinistix tests that were originally given out. Of the total 1,569 returned Clinistix there were 54 with positive results for the presence of glucose and 55 with indefinite results indicating further examination.

In the foot inspection, 25.2% of the total attendance was examined. It was found that 25.3% of the males who lived in Salford required treatment for defective foot condition and 28.7% of the females. Of those people who did not live in Salford 16.4% of the males required further treatment compared with 22.4% of the females who were not residents in Salford.

The cervical smear was limited to women of the age of 25 years and to women who lived in Salford. Of those who attended, 17.9% had a cervical smear taken at the time of the check-up, 13.7% were given an appointment, 15.7% refused and 12.7% had already had the test. Of the remaining 40% of the women who fitted into this category there was no information recorded.

There is some difference of opinion as to what can be regarded as abnormally high blood pressure. In the analysis of this data both systolic and diastolic missmes were included and the normal standards taken to be below 159 mms Hg Systolic and 84 mms Hg Diastolic. With these standards it was found that 6.8% of all examinations were shown to have high blood pressure and it is interesting to note that in the Salford residents the figures were 9.6% for the men and 8.5% for the women, whereas in the non-Salford residents corresponding figures show 3.6% and 4.7%. It is difficult to explain why a greater percentage of the people with high blood pressure lived in Salford, but part of the explanation may be due to the differences in social economic groupings in each population and also because there were more people of over 50 years of age who lived in Salford and attended for check up.

SALFORD HOUSE

Salford House provides separate cubicle accommodation for 285 men, the charge being 35/- per week or 5/6 per night, and the average number of residents per night was 277. This was a slight decrease on the previous year, largely owing to a reduction in the number of the older and more permanent residents. Some of these were transferred to the Homestead or other old peoples homes. This has resulted in a larger proportion of casuals and short term residents.

Of the total, approximately 55% were old age pensioners, or disabled men, 30% were in regular employment, 5% were unemployable and 10% were casuals staying for one night only.

Regular weekly calls were made by the health visitor, who was able to give help and advice in the many health problems which arise among the older men in the hostel. In co-operation with local hospital officials, a number of residents were recommended for admission to various convalescent centres. Through the help of the Civic Welfare Department, several men were able to enjoy a fortnight's holiday at the Salfordian Home at Southport.

During the year, the hostel was visited by several parties of student nurses and a party of hospital social workers, who wished to see how a hostel of this type was run. A visit was also made by the Chairman of the Ministry of Social Security, Lord Runcorn, who showed great interest in the hostel, and in the type of men who live in it.

The Christmas Dinner was held on Wednesday 21st December, when 130 old age pensioners and disabled men enjoyed a really good meal. The cost of this was met from Social Club funds, helped by gifts from local tradespeople and others.

Fifty food parcels were received from the Wood Street Mission and twelve pensioners were provided with shoes and shirts by Booths Charities.

A start was made on the improvement plan for Salford House. This included the re-decoration of the Hall and Dayroom, resulting in a much brighter atmosphere. The Social Club, which is situated in the basement, and was beginning to look rather dark and dismal, was also re-decorated by the Members and now looks far more cheerful in its light colours.

The Club continues to be a very popular feature of the Hostel, and the residents find the Snack Bar, T.V., Billiards, etc., a great boon. The friendly atmosphere of the place also assists new men to establish cordial relations with their fellow lodgers.

Many men who travel up and down the country, and are used to life in other hostels of this type, rate Salford House as one of the best, and return whenever possible.